Maternal and Child Health Services
Title V Block Grant

State Narrative for South Carolina

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

/2009/ The signed Assurances and Certifications forms are kept in the official grant file. //2009//

/2010/ The signed Assurances and Certifications forms are kept in the official grant file. //2010//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

/2007/Through contracts, the Maternal and Child Health Bureau (MCH) engages families of children and youth with special health care needs in an advisory capacity to policy committees. In addition MCH contracts with Family Connections/Family Voices to staff an Insurance Resource Center for families; this resource center educates, informs, and trains families, advises South Carolina Department of Health and Environmental Control and South Carolina Department of Health and Human Services, the state Medicaid agency, on policy and convenes an annual task force regarding insurance access issues. MCH staffs the Expanded Medical Home Team (community providers expanding the practice of comprehensive medical homes) and the Commissioner's Pediatric Advisory Committee (pediatricians and family physicians advising policies impacting health and insurance) and an OB Task Force. MCH convened the Youth Advisory Council, a career leadership program for high school juniors and seniors, who have leadership potential in both their school and community.//2007//

/2008/Previous efforts to obtain public input through the MCH Bureau (MCH) website have been unsuccessful. MCH will actively pursue varied avenues to obtain public comment in the coming year. Citizens can still access the full block grant but the document's size and complexity may pose barriers to obtaining feedback. To address this, MCH staff have prepared a two-page executive summary of this year's grant and developed a brief, simple survey about the services currently provided and the perceived need for additional services. English and Spanish versions of the survey will be posted in a prominent place on DHEC's web site with links to the most current grant and the executive summary. MCH is obtaining technical assistance from DHEC's Division of Communication Resources and Office of Public Health Education to ensure the survey is written at the appropriate literacy level and is user-friendly. "Zoomerang" will tabulate survey results via an existing agency-wide contract. Print copies of the surveys and the executive summary will be available through a variety of distribution points for consumers without computer access. MCH staff will also present the executive summary for discussion to multiple, diverse groups throughout the year, including DHEC staff at the Central Office and regional levels, meetings geared toward health professionals such as physicians, dentists, nurses, social

workers, health educators, and nutritionists, advocacy groups, and academia. MCH will also ask the DHEC Division of Communication Resources for additional suggestions for obtaining public comment. With their assistance, MCH will publicize the new methods for seeking input through press releases and direct contact with multiple, diverse agencies and community partners spanning the target population. The feedback obtained will be used as a resource for determining MCH areas of focus for the coming year.//2008//

/2009/The online survey process is not finalized with work to continue next year. A 2-page executive summary (see attachment) of the FY 2008 MCH Block Grant was distributed, discussed and explained to numerous external and internal groups with their feedback incorporated into this year's grant.//2009//

/2010/ No progress was made with the online survey due to loss of staff. The focus for the coming year will be engaging the public in the needs assessment. At that time we will also solicit input regarding best ways to ensure the public can access information about the block grant. Due to last year's success with the block grant's executive summary, MCH again prepared and distributed an executive summary to a number of community partners but geared it more to consumers than to professionals. Jackie Richards from Family Connection is now SC's AMCHP family delegate. In this role, she will focus on engaging parents of CSHCN into the block grant and needs assessment processes. //2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2008/ MCH has not completed a formal update of the needs assessment during the past year. However, each division and program area's ongoing assessment efforts are well-documented throughout the grant narrative. In addition, the eight health regions are conducting needs assessments to identify their areas of focus for the coming year as outlined in the overview.//2008//

/2009/MCH has not completed a formal update of the needs assessment during the past year. Planning has begun for the next MCH Block Grant 5 Year Cycle.//2009//

/2010/MCH has not completed a formal update of the needs assessment during the past year. Planning has begun for the next MCH Block Grant 5 Year Cycle. A core Needs Assessment workgroup comprised of internal MCH staff has been established and is currently working on the Assessment. The core workgroup has identified a theoretical framework for conducting the Needs Assessment. The group has decided to organize by six sub-population workgroups focused on: Pregnant Women, Infants, Children, Children with Special Health Care Needs, Adolescents and Reproductive Age Women. Plans are to develop expanded workgroups of 7-10 internal and external stakeholders with specific content expertise. Each expanded workgroup will utilize the PRECEDE/PROCEED theoretical framework to identify health needs and focus on potential solutions to address the identified health needs. Each expanded workgroup will provide up to five "Needs" felt to be critical for improving the health and well being of each respective population. The final ten priorities and performance measures will be selected from the information provided by the expanded workgroups.//2010//

III. State Overview

A. Overview

/2007/The low income for many families makes it difficult to provide the material and environmental enrichment necessary for healthy child development. Single parent families are also most likely to be poor.

The low socioeconomic status of many South Carolinians continues, as does associated health, education and behavioral risk factors. Mothers and children in our state are particularly affected. Of the children living in SC, 31.3% are in single parent families, 18.8% living in poverty, 35.6% not graduating from school, 37.1% of high school students using alcohol and 20.1% using drugs each month suggest that too many are at risk of not growing up to become self-supporting adults, good family members and responsible community citizens.//2007//

/2008/According to 2005 SC Kids Count data, 23% of SC's children lived in poverty and 38% lived in single-parent households. SC's overall Kids Count ranking was 47th. DHEC continues to participate in efforts to improve health indicators and disparity rates, especially those related to women and children.//2008//

/2007/There are many positive developments to report. The majority of children and youth in South Carolina are doing well. For the state, 86.7% of children are born to non-teen mothers age 20 or older, 58.9% are born to married parents and 68.7% live in two parent families; 81.2% were not poor and 57.1% lived in families with incomes two times above the federal poverty level; 89.9% of babies were born with normal birth weights; 70.4% were assessed as ready for the first grade, 66.3% scored basic or better on PACT for 8th grade math and 74.7% for 8th grade reading, 76.1% passed all parts of HSAP in the 10th grade and 64.4% graduated with their class. In a typical month, 62.9% of high school students do not drink alcohol, 79.9% do not use drugs and 74.7% do not smoke.

DHEC has recently unveiled its 2005-2010 Strategic Plan. The 10 state priorities identified in the Needs Assessment are nested into this Strategic Plan. Administration of the Title V Block Grant is truly a collaborative effort, touching and relying on many state agencies. A helpful by-product of the Grant is this coordination of systems.//2007//

/2008/MCH staff has worked diligently to move forward the MCH priorities. Due primarily to limited staffing and budgetary constraints statewide, MCH delayed full implementation until April 2007. The new MCH Director then met with Regional Health Directors to present a plan that focused on MCH outcomes within the framework of the previously-established priorities. A workgroup comprised of key regional and state-level leaders developed a reporting template to assure accountability and progress toward MCH goals within the DHEC's Strategic Plan. The regions will choose populations and activities to address depending upon local data, resources, and identified needs. Each region can choose to address the entire population or a subset. For example, a region could design a strategy that will address all female teens in a given county or region, or limit the strategy to teens seen in DHEC family planning clinics. Populations can be limited to one county, more than one, or the entire region. Strategies must be evidence-based and can be focused upon DHEC being the provider of the service or intervention or a partnership or train-the trainer approach. Strategies can be added, deleted, or modified during the planning cycle and year-to year. Each strategy must include at least one specific performance measure that will be monitored by the region and MCH on an annual basis. For the infant population specifically, regions must include two strategies: provision of newborn home visits and necessary follow-up of metabolic and newborn hearing screening. At least one additional strategy must be provided for this population. For the CSHCN population, regions must implement at least the following two strategies: referral and appropriate completion of the CRS application for services and care coordination as defined in the current policy. Regions must include at least one strategy for each MCH population group.//2008//

/2007/All MCH Title V Block Grant performance measures are in the DHEC performance management system. Additional detail is contained in Section IV.A.

The MCH Bureau has received the Early Childhood Comprehensive System Planning Grant and is working with a wide array of community partners to initiate.

A key agency value is customer service - meeting our customer's needs and providing quality care. DHEC has measured customer satisfaction for the past 6 years and tracks consumer familiarity with DHEC, use of services, overall satisfaction with the quality of service, satisfaction with specific aspects of service (waiting time, courtesy and staff attitude), staff competence and ability to answer questions and accessibility. Overall, DHEC has a positive public image and South Carolinians are satisfied with the services the agency provides. Customer service is assessed at every level of the agency and in all consumer groups. DHEC uses customer feedback to continuously improve its operations. Through this continuous quality improvement process, policies, practices and procedures are changed, as appropriate, to more effectively meet the needs of customers and stakeholders. Examples of these efforts include 1) a director of constituent services has been appointed to handle customer issues by providing a central point of contact, responding in a timely manner and identifying possible trends and 2) changing of clinic layouts, signage, hours of operation, location of services and flexible appointment systems are primarily based on customer feedback and funding availability. A 2006 Statewide Customer Satisfaction Survey confirms that South Carolinians have a positive image of DHEC. According to the University of South Carolina's Institute of Public Policy and Research, who conducts the study, South Carolinians are generally satisfied with services they received, the courtesy and attitude of staff, and the staff's ability to answer questions and provide information. This is a complement to the dedication and commitment of DHEC staff through challenging economic times.//2007//

/2010/ Staff reported progress on all strategies for the MCH population groups selected. This information will be incorporated into the upcoming MCH needs assessment. Activities will then be reported through the needs assessment process.//2010//

/2008/The Statewide Customer Satisfaction Survey for all DHEC services was repeated in the Fall of 2006 and confirms that customers are satisfied with the services that they receive. In addition to this random telephone survey, DHEC Health Services conducted Client Satisfaction Surveys in 2005 and 2006. Regional staff distribute client satisfaction forms to every client receiving services within a designated one-week period. The surveys include many respondents from Child Health, Children's Rehabilitative Services (CRS), BabyNet, Family Planning, and WIC. 98.2% of clients surveyed in 2005 and 98.3% in 2006 would recommend DHEC services to others.//2008//

/2009/Consistent with data from 2005 and 2006, the 2007 Health Services Survey indicates 98% of clients would recommend DHEC services to others.

FIMR presents information to community groups who develop interventions to reduce these deaths. The Care Line is a resource line and provides a forum for concerns to be voiced. In 02/2008, the Division of CSHCN met with stakeholders to discuss priorities for continued CRS coverage of health and supportive services. This group suggested priorities for redesign of the CRS service delivery system. The WIC Program surveys participants yearly to determine their selections from the current food package.//2009//

/2007/The families we serve are important stakeholders in the services they receive. DHEC continues to work with families to determine their needs. An example is the Youth Advisory Council, a group of youth with disabilities and chronic illnesses who will provide consumer input into transition curricula, conference planning and priority setting. Through contracts, the MCH engages families of CYSHCN in an advisory capacity to policy committees. In addition MCH

contracts with Family Connections/Family Voices to staff an Insurance Resource Center for families; this resource center educates, informs, and trains families, advises SC DHEC and SC Department of Health and Human Services, the state Medicaid agency, on policy and convenes an annual task force regarding insurance access issues. MCH staffs the Expanded Medical Home Team (community providers expanding the practice of comprehensive medical homes) and the Commissioner's Pediatric Advisory Committee (pediatricians and family physicians advising policies impacting health and insurance). MCH convened the Youth Advisory Council - a group of youth with disabilities and chronic illnesses who will provide consumer input into transition curricula and activities and assists with the SC Youth Leadership Forum- a career leadership program for high school juniors and seniors, who have leadership potential in both their school and community.

The MCH Bureau is focused on building partnerships with both traditional and non-traditional partners. Over time the desire is to build the infrastructure necessary to provide service with a decreased emphasis on the direct delivery of care. This is a gradual process that will engage multiple partners and take many years.

As the structure of health care evolves, new opportunities allow DHEC to build and expand partnerships. This effort is highlighted throughout this report. In spite of economic challenges, DHEC continues to develop and maintain relationships with pediatricians, family practice physicians, obstetricians, specialty physicians and dentists. Links with community providers, schools and other organizations have been strengthened through collaboration. By joining forces with others, DHEC has forged initiatives to improve access to and quality of service. After a period of decline, partnerships with the state's medical and dental providers are increasing and improving the ability to serve families.//2007//

/2009/Due to the statewide implementation of managed care, MCH's partnership role is increasingly critical. The current focus is working with providers to promote excellence in client care management.//2009//

/2010/ The MCH Bureau continues to focus on building partnerships. DHEC has developed and maintained provider advisory groups, continues community linkage efforts through partnerships, and has collaborated with new and existing partners on various initiatives.//2010//

/2007/As an example, South Carolina Turning Point is a public-private group that supports community development and planning activities. Turning Point helps local initiatives assess community health through collaborations with the government, business sector and the community. Activities include conducting assessments of community health services, developing a health improvement plan and fostering leadership and partnership skills with stakeholders and partners. Plans are being made to implement this process statewide. DHEC has the lead role in facilitating this community wide systems approach to build a strong and effective local public health system. Another partnership example is South Carolina's Partners in Transition. This is an interagency group committed to making a change in the lives of students with disabilities who are transitioning from their local schools into post-secondary education and/or the community and workplace. The group includes student members and parent partners who assist and advise the committee on setting goals and objectives that center around transition issues. Agencies currently involved with this committee are DHEC, Children with Special Health Care Needs Divsion, Developmental Disabilities Council, Office of the Governor, Vocational Rehabilitation, Continuum of Care, State Department of Education, Midlands Technical College, SC Assistive Technology Project, Swansea High School, PRO-Parents, Family Connection, USC Center for Disability Resources and the SC Department of Corrections.//2007//

/2008/This is the third year of SC's implementation of planning efforts funded by the President's New Freedom Initiative: State Implementation Grants for Integration of Community Systems(ICS) for Children with Special Health Care Needs (CSHCN) and the Early Childhood Comprehensive

Systems Grant (ECCS). Parents serve as key members of all work groups associated with these grants. To ensure families have first-hand input into the design of seamless systems of care, DHEC has established contracts with three statewide parent advocacy and support groups: Federation of Families for Children's Mental Health of South Carolina (FOF), Parents Reaching Out to Parents of South Carolina, Inc. (PRO-Parents) and Family Connection of South Carolina, Inc (Family Connection). PRO-Parents and the FOF are assisting DHEC to establish and maintain a functional Youth Advisory Council. DHEC will also place a parent resource staff member in the Medical Home Network (MHN) at the University of South Carolina (USC) School of Medicine to provide care coordination and family-to-family support.//2008//

/2010/ The USC/SCS Medical Home Network Partnership continues to grow. Funding has been secured for another year for the public health care coordinator and the parent partner who provides services in the clinic two days per week. //2010//

/2008/Building on the success of last year's first Youth Leadership Forum (YLF), South Carolina's Partners in Transition is planning a two-day event this year. CSHCN and Women and Children's Services (WCS) staff participated in planning the YLF and disseminated application materials.//2008//

/2009/Last year's YLF was held July 13-14, 2007, at USC. 19 delegates representing all areas of SC participated in this event.//2009//

/2010/ CSHCN staff transition priorities focused on current clients impacted by program policy change from an age cut off of 21 years old to 18 years old. //2010//

/2008/In accordance with a needs assessment conducted in late 2006 and early 2007 to set future directions for the Division and state CSHCN activities, the CSHCN Division Director has re-established or initiated contact with a number of "old friends" of Title V and new stakeholder groups. These interactions are increasing understanding of the role of the state CSHCN Program and setting the stage for better coordination and collaboration across a range of stakeholders beyond physician groups. These stakeholders include family support organizations (e.g. Federation of Families), SC's IDEA parent information grantee (PRO-Parents), statewide child advocacy groups focusing on all children (e.g. Voices for SC Children) or children with specific illnesses or conditions (e.g. SC Epilepsy Foundation), and other entities serving CSHCN (e.g., Federally Qualified Health Centers [FQHC]). Job descriptions for requested positions include responsibility for establishing and/or maintaining working relationships with these and other organizations.//2008//

/2010/ CSHCN partners assisted with the planning and communication of difficult program policy changes related to budgetary constraints for clients as well as professional staff. Future efforts are focused on joint planning to build upon current successful outreach projects to benefit both CSHCN families and professionals. //2010//

/2007/The Division of Oral Health provides two great examples of partnerships. The South Carolina Oral Health Coalition, formed in 2003, consists of 80 members and includes partnerships from a broad stakeholder group whose purpose is to develop oral health promotion and disease prevention activities at the state and community level. The South Carolina Oral Health Advisory Committee consists of 20 members who developed the State Oral Health Plan that has identified five priorities: policy and advocacy, prevention and education, dental public health infrastructure development, dental workforce development, and access to oral health services.//2007//

/2008/The Oral Health Advisory Council and Coalition have contributed to the Division of Oral Health (DOH). Because of communication and coordinator challenges, focus groups were held with the two groups to clarify roles and expectation for each group. The process resulted in a new structure for the two groups. In addition, the DOH has formal agreements with the Budget and

Control Board's Office of Research and Statistics (ORS), USC Arnold School of Public Health, Voices for South Carolina's Children, and EdVenture Children's Museum. Another key public-private partnership exists between the DOH and seven School Dental Programs that provide dental services in the schools under the public health section of the Dental Practice Act.//2008//

/2009/Since 2005, partnerships have been developed with the DOH through the South Carolina Oral Health Advisory Council and Coalition (SCOHACC). This has created a network of oral health advocates who disseminate information and alert DOH to collaborative opportunities. Each member of the DOH team participates on a variety of advisory committees and project teams outside of their agency. Internal DHEC Oral Health Partnerships: under the leadership of MCH Director, Brenda Martin, the DOH continues to enhance its partnerships within the Bureau. Ms. Martin also serves on the SCOHACC and is providing leadership for the development of Oral Health Practice Guidelines during Pregnancy, as prioritized by the SCOHACC's early childhood workgroup. The WIC program still distributes the DOH "First Birthday Card" which includes a toothbrush and education to new moms on caring for their infants' teeth on age 1 recertification visits. To date over 25,000 cards and toothbrushes have been distributed by the WIC program. The DOH partnered with the DHEC's ICS Grant to develop with the USC School of Medicine, Department of Pediatrics, the Center for Disability Resources, an online version of the Oral Health for Families of Children with Special Health Care booklet (http://uscm.med.sc.edu/oralhealth/index.htm.).//2009//

/2010/ DHEC's Division of Oral Health, the Department of Education's Healthy Schools and the South Carolina Dental Association (SCDA) conducted seven regional oral health trainings for over three hundred School Nurses during the 2008-2009 school year. This led the SCDA and the American Dental Association to fund a survey of school nurses to determine the degree to which children enrolled in the state's public schools have access to dental care through school-based partnerships.//2010//

/2008/This past year has been very productive for partnership enhancement through work with inter-agency stakeholders and the ECCS. Integrating systems of care for the early childhood period through partnerships promotes the likelihood that children will be healthy and ready to learn at school entry. Also, partnerships with managed care continue to demonstrate promise as medical practices work with public health to promote excellence in practice as well as quality patient care management. See activities related to ECCS and the ICS grants under Section B, Agency Capacity.//2008//

/2010/ECCS partnered with Greenville Hospital's Developmental Behavioral Pediatrics Department and the PRIDE program to be awarded one of the first Commonwealth technical assistance grants to replicate Connecticut's Help Me Grow(HMG) system. Extending from the DHEC Medical Home grants, ECCS partnered with the Children's Trust of SC to secure an Administration for Children and Families (ACF) grant for evidence-based home visitation programs that focuses now on research identifying attributes for succesful site implementation and will partially fund a new DHEC nurse administrator position for NFP.//2010//

/2007/A goal at DHEC is to promote culturally competent, family centered care by supporting and promoting family and professional partnerships at all levels of decision-making. A Cultural Competence Work Group (CCWG) has been established and convened. This group is composed of representatives from: Bureau of MCH staff; Division of Perinatal Systems; Division of Oral Health; Division of Women's and Children's Services; DHEC Office of Minority Health; DHEC Bureau of Communicable Disease and Community Health Chronic Disease Prevention; members from the community; academic organizations; and family representation for CYSHCN. This group will research available resources to assist MCH in completing a self-assessment of its internal organization and cultural competence. Training and staff development activities will be planned to address the strengths and deficiencies identified through the self-assessment. The CCWG has initiated dialogue with the National Center for Cultural Competence (NCCC) and is reviewing the

available organizational self-assessment tools and evaluation strategies from the NCCC and the Office of Minority Health, with the focus being on self-assessment and change theory. Both organizations will work with MCH and its external partners to 1) become more skilled in promoting partnerships with families; 2) develop more effective strategies to work with families at the community level; and 3) assist staff in developing skills and activities that will direct their efforts more towards enabling and infrastructure activities on the MCH Pyramid. To further involve providers and families in cultural competence and family-centered care, a presentation was made to the DHEC Commissioner's Pediatric Advisory Committee. This presentation focused on the data from the National Child Health Survey. From review of this data, disparities were evident regarding families' perception of care received in a medical home. African American and Medicaid families were significantly more likely to feel uninvolved in their care. When this data and Medicaid claims data, obtained through partnership with the SC Budget and Control Board, Office of Research and Statistics (ORS), is further analyzed and formatted into an environmental scan, there will be ongoing data shared with the DHEC Pediatric Advisory Committee. This group will be requested to give input into framing a system of care for children, that is culturally competent and family centered.//2007//

/2008/The Cultural Competence Work Group researched and reviewed existing available resources for organizational self-assessment and engaged in preliminary dialogue with the National Center for Cultural Competence. The Center's existing tool focused on an organizational self-assessment for an agency whose main focus was to provide direct services, therefore, DHEC could not use the Center's tool in its existing format and redesign would have proven cost-prohibitive. Several other factors contributed to MCH taking another approach including a change in MCH leadership and reorganization of DHEC's 13 public health districts into 8 public health regions (see Public Health Regional Map in attachment). Time was needed for MCH to assess Central Office and Regional staffing capacity, reassign staff where necessary and make any other adjustments. All MCH staff was trained on change concepts. In addition, MCH began to develop its priorities. As the priorities are being developed, MCH will be in a much better position to formally assess its organizational structure.//2008//

/2009/MCH collaborates with DHEC's Cultural Competence Management Team to assure the provision of culturally competent services for all clients. Cultural competence links have been integrated into the USC School of Medicine's Team for Early Childhood Solutions modules.//2009//

/2010/ MCH continues to assure provision of culturally competent services for all clients. Cultural competence standards are incorporated into each employee's formal evaluations and printed/electronic media are closely reviewed to ensure adherence to the agency's cultural and linguistic competency policies. The cultural competence Internet links on the USC School of Medicine's Team for Early Childhood Solutions website have been updated//2010//

/2007/Training is critical in achieving this goal of cultural competence and family centered care. A contract was completed with the USC School of Medicine, Teaming for Early Childhood Solutions (TECS), to develop web-based interactive learning modules (cultural competence, insurance, oral health, infant mental health, and family-centered care) and an interactive Managed Learning System. These modules will be written for both families and professionals and available for statewide use.//2007//

/2008/The Cultural Competence Work Group researched existing cultural competence resources and identified information for professionals and families. Instead of duplicating resources, cultural competence links for providers, professionals and families will be incorporated into all of the USC School of Medicine Team for Early Childhood Solutions (TECS) modules.//2008//

/2007/The rate of very low birth weight, early prematurity, and infant mortality of black and other mothers are over two times those of whites. The larger racial disparities persist at comparable

levels of maternal age, education, income and marital status. The gap between white and other populations for many health indicators is not improving.

Racial disparities continue to exist and are a priority for DHEC. These disparities are being addressed at all levels of the MCH pyramid. DHEC efforts target eliminating health disparities in 6 critical areas by 2010. These areas are infant mortality, cancer screening and management, cardiovascular disease, diabetes HIV/AIDS and immunizations.//2007//

/2008/Infant mortality is one of the six priority health disparity areas affecting minorities in South Carolina. In 2004, minority babies in South Carolina were 2.3 times more likely to die than white babies during their first year of life. SC black infants were almost two times (1.99) as likely as white infants to be born at a low birth weight in 2004. Women who begin prenatal care early and continue care throughout pregnancy reduce the risk of complications during childbirth. The percent of women beginning prenatal care in the first trimester in 2003 for white females was 80% compared to black females at 69%. Some contributing factors leading to racial and ethnic health disparities in infant mortality are age, cigarette smoking, alcohol consumption, unintended pregnancies, cultural beliefs, obesity, and lack of education. Community based approaches that engage the minority community hold promise for addressing infant mortality and other maternal and child health issues which disproportionately impact racial and ethnic populations.//2008//

/2009/Infant mortality will be a focused agenda for MCH this coming year. Efforts are ongoing with the Office of Minority Health, MOD and others to address the growing disparity in SC. Much work is needed as the problem continues to grow.//2009//

/2010/ Preliminary 2007 data indicates the black/other infant mortality rate will be lower than the 2006 and 2005 rate, representing a decline in 2 consecutive years. Despite an overall decline, racial/ethnic disparities related to infant mortality remain persistent.//2010//

/2007/DHEC has made great inroads into the expanding Latino community by having a staff member serve as ex-officio chair of the South Carolina Hispanic/Latino Health Coalition, which addresses Latino health issues. DHEC also distributes culturally appropriate cardiovascular health and disease materials to Latinos at community events and through community based organizations. The Hispanic population continues to increase disproportionately. The number of live Hispanic births was 4,332 in 2005 or 7.8%. Overall, the number of Hispanic children 0 through 24 was 53,317 or 3.7%.//2007//

/2008/To address health disparities, MCH continues to work with a project in DHEC Region 6, "Closing the Gap on Infant Mortality (CGIM): African American-Focused Risk Reduction". Concluding its third year of grant funding, this project was developed and implemented for the specific purpose of reducing infant mortality among black infants in Horry, Williamsburg and Georgetown Counties. The program's goals are to implement and assure the practice of evidence-based medical treatments during prenatal care, delivery and the first year of life, increase community awareness and knowledge of infant health issues including impact of chronic diseases and preconceptional health on birth outcomes, and increase the depth of knowledge and understanding about the causes of fetal and infant deaths in the target area. The first goal is being addressed by keeping the medical community informed of best practices including use of glucocorticoids, screening for Group B Strep, use of 17P for preterm birth prevention, use of multiple injection insulin regimens, and screening for coronary artery disease. The second goal is being addressed through community outreach and case management of pregnant women and infants. A total of 6 Public Health Assistants (PHA) case manage pregnancies from the time the woman knows she is pregnant until the infant is one year old. The PHAs and health department staff also hold many community forums providing information about chronic disease and its impact on healthy pregnancies. Fetal and Infant Mortality Review (FIMR) has been started in Horry and Williamsburg Counties to address the third goal. Hospital and health department staff review all fetal and infant deaths and bring the information from these reviews to the community groups. FIMR has found that there are still too many unplanned pregnancies, some parents do

not follow safe sleep practices, and interconceptional spacing is not the recommended two-year interval. Lack of transportation in rural areas makes it difficult for pregnant women to get Medicaid in a timely manner and to keep appointments. These three interventions are ongoing and will hopefully have a positive impact on infant mortality The region had problems initially filling all positions so the grant monies will be continued into a fourth year.//2008//

/2009/CGIM has had a positive impact on reductions in LBW infants through its intensive case management program. Of 524 women enrolled in the program, only 14 delivered infants weighing less than 5 pounds.//2009//

/2010/ CGIM services will be provided through June 30, 2009 at Pee Dee Healthy Start through a final no-cost extension.//2010//

/2007/While continuing to trend below Healthy People 2010 objectives, South Carolina continues to make progress with prenatal care. The number of women beginning prenatal care in 2005 was 68%. Similarly, the Kotelchuck Index has narrowed in 2005, with 85.1% of all women receiving adequate prenatal care.//2007//

/2008/As DHEC no longer provides prenatal care in SC, the role of the local health departments is now one of referral to providers and encouraging women to enter care as soon as possible. Most of the calls to the Care Line (the toll free number required by the MCH Block Grant) are from women looking for a Medicaid provider for their pregnancy. The Family Planning Program and WIC also direct pregnant women to appropriate services. In 2005, 72.9% of the white population entered care in the first trimester compared to 62.1% of the black population. This was actually a decrease from 2004 for the white women (76%) and an increase for the black women (59%). Barriers to early prenatal care continue to be timely access to Medicaid especially since yearly renewal to the program and proof of citizenship were added as requirements and finding a Medicaid provider in the rural areas of South Carolina. A growing concern is the number of undocumented immigrant women who receive no prenatal care and use emergency Medicaid for their delivery. MCH is assessing how other states are meeting these needs. In addition, the DHEC Commissioner's Obstetric Task Force (SC OB Task Force) is convening a work group to address this issue. The SC OB Task Force was initiated with the first meeting in April 1999. Meetings are held four times a year in Columbia. The Division of Perinatal Systems in MCH supports the SC OB Task Force. Its purpose is to advise, identify and plan strategies to improve maternal health and birth outcomes in SC which include: a) Improving prenatal care entry and participation (access, risk screening and referral); b) Reducing unintended pregnancy (maximize the family planning waiver and increase the interconceptional period); c) Increasing emphasis on preconceptional health: recognition of importance by providers and women, making this a routine part of a visit, and working with third party payors for appropriate reimbursement. SC OB Task Force members are obstetricians selected from different geographic areas in the state who represent different hospital levels of care (Level I, II, III and Regional Perinatal Centers) as well as private rural practice, medical center/education programs, public health, family practice, and community health centers. There are currently 13 obstetricians on the SC OB Task Force with six original members still participating. The SC OB Task Force Chair is DHEC's Commissioner. Representatives from the Medicaid agency, SC Chapter of the March of Dimes (MOD), SC Medical Association, SC Hospital Association, DHEC's Deputy Commissioner for Health Services, the MCH Director as well as DHEC program managers from Perinatal Systems, WCS, STD/ HIV, Public Health Statistics and Information Services, and the Office of Minority Health. Issues that the SC OB Task Force have been concerned with over the last 7 years include: Infant Mortality data, issues, trends, contributing factors, grouping of deaths into categories by race, county, state compared to the US; racial gap; utilization of PRAMS data to see trends in perinatal population (smoking, Back to Sleep, multivitamin use to prevent Neural Tube Defects, etc.); Medicaid issues: eligibility process and access to care; verification process to avoid delay in getting prenatal care; care for the undocumented; proof of citizenship requirements; Medicaid Managed Care and Medical Homes initiation and implementation; plans to increase enrollment and roll out system; Primary Care Case Management; 17 Alpha-hydroxyprogesterone access and

claim process; Postpartum newborn home visits, family planning for women and care after delivery; Prematurity/short gestation issues, the MOD Prematurity Prevention Campaign and Premature Birth Leadership meeting; Undocumented immigrant pregnant women needs, access to care and reimbursement; large increases in the number of undocumented pregnant women needs statewide attention for financial and access to care issues; SC Neural Tube and Folic Acid Campaign: seen a decrease of Spina Bifida in SC by 50%; need to address importance and use of multivitamins; Birth Defects Surveillance Bill passage and statewide program implementation; Preconceptional and interconceptional education including what to do to improve health before and during pregnancy. MMWR Recommendation to Improve Preconceptional Health and Health Care; Caring for Tomorrow's Children: Having a Healthy Baby Book; Hepatitis HBIG; Malpractice issues for OB providers and impact on care; Vaginal Birth after C-Section by Licensed Midwives: licensing issue; DHEC's Electronic Birth Certificate system for Verification of Citizenship for Medicaid; Legislative updates and advocacy issues.//2008//

/2009/The rapid expansion of Medicaid Managed Care in SC in 2008 has had a potentially negative impact on access to prenatal care. Through auto-enrollment, some women are switched to insurance companies their providers do not accept in the middle of their pregnancies leading to confusion for all parties involved. 1 of the managed care companies does not have a tertiary center in its network leaving high-risk women without an appropriate level of care. The OB Task Force is working on these issues with DHHS.//2009//

/2010/Medicaid Managed Care continues to be a barrier for access to prenatal care as automatic enrollment of clients continues. The OB Task Force and Medicaid representatives continue dialogue around this issue.//2010//

/2007/Disorders relating to premature births and low birth weight are still among the leading cause of infant deaths. A total of 524 babies born to South Carolina women during 2004 died before their first birthday making the state's infant mortality rate 9.3 per 1,000 live births compared to 2003's rate of 8.3 and 9.3 in 2002. Deaths of black and other racial and ethnic minorities at a rate of 14.7 per 1,000 live births continue to be more than twice that of white babies at 6.4. The leading cause of death in 2004 for South Carolina infants was congenital malformations. The data confirms that babies are being born too early and too small, many without adequate prenatal care. Pregnant women can improve their unborn baby's health by planning their pregnancies, being sure they are healthy before a pregnancy and letting the gestation period extend naturally to its full term whenever possible. Risk factors rise for poor pregnancy outcomes if maternal complications are not under control before and throughout the pregnancy. Strategies to combat infant mortality are constantly being evaluated and must be based on sound science.//2007//

/2010/ The 2006 South Carolina infant mortality rate of 8.4 deaths per 1,000 live births represents a 12 percent decline from the 2005 rate of 9.4 deaths per 1,000 live births. Preliminary 2007 rates are very near the 2006 rate.//2010//

/2008/DHEC does not have 2005 or 2006 final data but continues to work to address infant mortality as well as preterm births. As the rate of preterm births increases, so do infant mortality rates. MCH works closely with the MOD to support programs looking at the problem of preterm birth. Women delaying childbirth and using fertility treatments have also increased the number of multiple births which increase the risk of infant loss.//2008//

/2008/Family Planning continues to be a strong program in SC and the state is working diligently to encourage all reproductive age women to plan and space their pregnancies as well as be in optimal health before they become pregnant.

MCH and the Births Defects Surveillance Program continue to promote folic acid. A recent survey of folic acid use in SC shows there are less women taking vitamins and a decrease in knowledge about the importance of folic acid. Blood folate levels have also been decreasing in

recent years. The health departments are distributing vitamins through the family planning clinics and continuing to educate about the importance of folic acid intake.

Through the FIMR program, communities are continuing the Back to Sleep campaign and adding a new "Safe Sleep" campaign because recent reports indicate more babies may be dying from positional asphyxiation and co-sleeping in an unsafe environment.//2008//

/2009/Shaken Baby legislation mandated that beginning 01/01/2008, a video is offered in hospitals for all new parents to view at the time of delivery. Perinatal Systems recommended a video, and through Perinatal Regionalization and the SC Hospital Association, DHEC was able to assure that all hospitals have the appropriate videos, knew of the law and were instructed to have parents sign the Parental Consent Form. Perinatal Systems ensured all healthcare providers were aware of the AAP's "Practicing Safety Program" aimed at decreasing child abuse and neglect. Brochures and materials were reproduced and sent to all pediatricians, OBs and family practice providers.//2009//

/2010/According to 2006 Vital Records data, there was a slight decline in SIDS deaths from 2005 to 2006; however, infant deaths due to accidental suffocation and strangulation in bed have steadily increased since 2003. March of Dimes grant money has been used to develop a Safe Sleep training tool for providers and is currently being distributed.//2010//

/2007/The percentage of low birth weight babies remained at 10.1% in 2005. These babies are at greater risk for health and development problems and are associated with mothers in their teens, with less than a high school education, unmarried, smokers and experiencing stress or abuse.//2007//

/2008/The rate of low birth weight babies (< 2500 grams) is a growing public health problem that affects families, and costs society billions of dollars each year. Unlike many other health problems, the rate of preterm birth has increased in the last decade. There are also troubling and persistent disparities in preterm birth rates among different racial and ethnic groups. The highest rates are for Blacks and the lowest are for Asians or Pacific Islanders. Term births resulting in low birth weight babies are poorly understood. Causes may include individual-level behavioral and psychosocial factors, neighborhood characteristics, environmental exposures, medical conditions, infertility treatments, biological factors, and genetics. To date, no single test or sequence of assessment measures that may accurately predict preterm birth are available.

MCH continues to work with providers to increase access to early and continuous prenatal care, encourage the use of ultrasound early in pregnancy to establish gestational age and develop indicators of maturational age. With the MOD, MCH is working on the "I Want My Nine Months" campaign. MCH is working with community groups and Healthy Starts to encourage planned pregnancies for women with a focus on healthy weights and lifestyles before pregnancy. MCH continues to work with DHEC's Bureau of Community Health and Chronic Disease Prevention to promote an overall healthy lifestyle for women.//2008//

/2010/The overall rate of low birth weight babies (<25000 grams) remains relatively consistent with the overall percentage of low birth weight babies being 10.2% in 2006. Babies with lower birth weights continue to be more prominent among minority populations.//2010//

/2007/Expanding and diversifying the provider network for at risk mothers and children is a focus issue for the MCH Bureau. To bring efficiencies into the network, a focus has been placed on integrated systems and the establishment of a medical home for every child in South Carolina.//2007//

/2008/MCH continues to work on integrated systems and the establishment of a medical home for every child in South Carolina. Because of the active recruitment of providers by the Managed

Care Organizations, many more providers now accept Medicaid. In January 2007, MCH and the South Carolina Chapter of the American Academy of Pediatrics (SC AAP) hosted a Community Access to Child Health (CATCH) conference. A goal of this conference was to develop and enhance medical home partnerships. The conference had a diverse representation including DHEC Central Office and public health regional staff, physician practice staff, parents, FQHCs, and representatives from Managed Care Organizations. CATCH focused on using quality improvement to address change concepts, especially those that addressed developmental screenings. Twenty-two practices participated and over two-thirds indicated that they wanted to partner with DHEC to address partnership improvement. Many of these practices had not previously engaged in partnerships with DHEC. MCH's Medical Home Physician Consultant is collaborating with an MCH representative to provide technical assistance for the quality improvement cycles. Technical assistance visits involving physician practices and local DHEC staff have already been provided in two of the eight regions. Through this effort, DHEC staff has been able to explain in detail services such as CRS and BabyNet and practice staff have been able to connect names with faces. This is another major step toward building and improving integrated systems of care.//2008//

/2009/This year's CATCH meeting was held in January 2008. Attendees included 23 practices, 2 pediatric residency programs, DHEC regional and Central Office staff, and 3 managed care entities.//2009//

/2010/ The CATCH meeting was held in January 2009. The meeting focused on quality improvement initiatives and client care management. Partnership efforts resulted in 2 MCOs providing funding to sponsor the meeting. Attendees included 3 pediatric residency programs, DHEC regional and Central Office staff, managed care, Medicaid, and 24 medical practices.//2010//

/2008/Two key staff members of the National Medical Home Autism Initiative at the Waisman Center For Excellence in Developmental Disabilities at the University of Wisconsin-Madison, Christine M. Breunig, Senior Outreach Specialist, and Linda Tuchman-Ginsberg, Outreach Program Manager, attended the January 2007 CATCH meeting. They updated participants on the work of the center with particular emphasis on the National Medical Home Autism Initiative (NMHAI), a cooperative agreement with MCHB/HRSA. A SC team which included representatives of both families and government systems were identified: a parent and the School Social Work Consultant (State Department of Education [SDE]/DHEC WCS, education and public health) to participate in the March 25-27, 2007, Family Forum: Family Perspectives on Autism Service Guidelines for the Medical Home. They joined with teams from 7 other states to provide input and the critical perspective of families and key stakeholders on how to move forward on the guidelines and address system requirements. Additional partnerships were established with representatives from the National Center for Medical Homes/AAP, Healthy and Ready to Work National Coalition, the Catalyst Center: Improving the Financing of Care, the National Center for Community Integrated Services, and the Center for Family Professional Partners/Family Voices. The Autism Service Guidelines for Medical Home Primary Care Practices provided a focus. Participants were tasked to study the Autism Service Guidelines as a first step toward a major goal of the meeting: to consider what it will take to influence national policy for improvement of a system of care for individuals with ASD. Recommendations from the group included revision to the Autism Service Guidelines for Medical Home Primary Care Providers to incorporate a stronger family voice in the system requirements as well as including additional promising practices. A strong message that NIH research indicates ASD should be considered a neuron developmental medical condition associated with unique abnormalities in brain development and not primarily a mental health or mental illness was recommended. Increased research is critical to strengthen the system of ASD services. Complex needs require a broad range of services. The critical shortage of professionals to serve children with ASD must be addressed. During the Family Forum meeting, it was requested that SC representatives meet with staff from NMHAI to discuss the possibility of SC hosting a Regional Conference on the Medical Home Autism Initiative, possibly sometime in mid to late 2008, and to participate via

conference call on a planning committee for such an event. An initial planning conference call was held with Christine Breunig, the MCH Medical Home Physician Consultant, and the School Social Work Consultant.//2008//

/2009/A SC parent with an autistic child and the WCS School Social Work Consultant participated as members of the ASD Family Forum convened in Washington, DC, March 2007.//2009//

/2007/The MCH Bureau continues to work on eliminating any barrier that affects access or the availability of service to all South Carolinians.//2007//

/2008/Changes in Medicaid eligibility requirements and the expansion of managed care into SC present barriers to families becoming eligible for Medicaid and in selecting the best Medicaid option to meet families' health care needs. Families will require additional support as they make important choices affecting their Medicaid health care coverage. As of July 1, 2006, all Medicaid recipients are required to provide directly to the Medicaid eligibility staff proof of citizenship at the time of the recipient's annual review. Although DHEC and the SC Department of Motor Vehicles are working with the Medicaid agency to develop an electronic system for citizenship verification, this system is not yet available. While some recipients are granted "reasonable opportunity" to obtain required documentation, these new requirements add another barrier to receipt of needed health care services. Another challenge to Medicaid recipients is the implementation of the Medicaid Enrollment Counseling Services which begin in the Midlands area of SC August 1, 2007. After 30 days of unsuccessful contact, a client will be randomly auto-enrolled in one of the state's Medicaid plan options. Although fee-for-service Medicaid remains as an option and is included in written materials describing the various Medicaid plans, Medicaid recipients must request the fee-for-service Medicaid option. Auto-enrollment for those Medicaid clients with special health care needs may affect access to health care services through either limited specialty providers and/or authorization requirements for services. Because the authorization process is not the same for MHNs and HMOs, there has been confusion between medical homes and other providers regarding responsibility for obtaining an authorization. DHEC is working with the managed care networks and plans close coordination with the enrollment brokers to maximize access to health care services and Medicaid eligibility. Critical to families, especially those with CSHCN, will be their understanding of which Medicaid managed care entity will best meet their needs. If none of the Medicaid managed care options are appropriate to address families' health care needs, then being knowledgeable that the fee-for-service Medicaid option is an available choice will be extremely important. Public health regional staff will continue to educate clients with barriers to optimal health care regarding fee-for-service Medicaid availability.//2008//

/2009/There are currently 7 Medicaid HMOs and 1 MHN in SC. Please see attached "Managed Care Organizations in South Carolina-July 1, 2008." Families, overwhelmed with the number of options, require additional support to understand the changes. Some providers have elected to enroll with only a few managed care companies, creating an additional barrier to care. Due to Medicaid auto enrollment, many families have been randomly assigned to a different plan from the one in which they were previously enrolled. Although SC has expanded SCHIP to 200% of poverty and more children may qualify, the strict eligibility requirements pose barriers to families applying. MCH continues to work with all stakeholders to address these issues impacting access to care.//2009//

/2010/ Auto enrollment of pregnant women and infants into MCO's continues to be a barrier to care. In addition, not all of the major hospitals in SC enrolled with all MCO's. Newborns are automatically enrolled in the plan in which their mother is enrolled. Pediatricians may not be enrolled with the same MCO, creating barriers to care for the newborn. Difficulty in obtaining authorizations has affected the ability to provide services. Enrollment in the fully funded SCHIP Stand Alone program has remained lower than expected.//2010//

/2007/Funding for the Childhood Lead Poisoning Prevention Program has sunset. The MCH

Bureau is exploring how to continue needed activities.//2007//

/2008/The Bureau of Environmental Health has taken the principal role in assuring that appropriate follow up assessments are done for children identified with lead poisoning. MCH staff at the local and state level still provide mandated follow up through the Infant and Child Health Follow Up priority.//2008//

/2007/Through the More Smiling Faces in Beautiful Places initiative, more than 75 medical professionals have received training to provide oral screenings, risk assessments, oral health education and preventive care to very young children. In addition, more than 125 dental professionals have received training to increase their ability to provide dental care to children up to the age of 5 and children with special health care needs. "Patient navigators" have successfully developed a system to link medical homes with oral health care providers, provide patients with resources, screen for eligibility in Medicaid and arrange patient transportation. These patient navigators have delivered oral health education to 4,653 parents, caregivers and children through community agencies and groups such as Head Start, Healthy Start, First Steps, faith groups and day care centers. This project is being piloted in 6 South Carolina counties.//2007//

/2008/ The Robert Wood Johnson grant, More Smiling Faces, ended February 2006 and the agency has not been able to sustain the patient navigator positions in the six pilot counties due Family Support Services (FSS) restrictions. In the final year of the grant, the training for the dental professionals was opened to the entire state. The percentage of Medicaid eligible children ages 1-5 who received dental services has increased from 30% to 39% for the state and nearly 41% for the 6 rural pilot counties. While there was concern that dentists might not see the younger children on Medicaid, the Medicaid dental utilization by age 1, 2, and 3 was increased from 4% to 11%, 15% to 25%, and 34% to 42%, respectively. MCH and DOH will be challenged to sustain these very positive results but every effort will be made to work with the managed care networks and Medicaid to do so.

With the end of the More Smiling Faces in Beautiful Places Grant, the DOH and MCH will continue to try to sustain positive results by working with Medicaid and the managed care entities. Beginning in October 2006, Medicaid coverage for four dental procedures that had been deleted were reinstated. This significant event means that Medicaid will now cover D0140- Limited Oral Evaluation, D2950-Core Buildup including Pins, D2954-Prefabricated Post and Core in addition to Crown and D3330- Endodontic.//2008//

/2010/The MCH Bureau has undergone changes in organization structure. See Capacity Section for Details.//2010//

/2007/Over the past six State Fiscal Years (2001-06), the Agency has experienced a cumulative state budget cut of 34.96% of state funds (2001-10%, 2002-6.5%, 2003-8.73%, 2004-8.73%, 2006-1%). There is an anticipated increase in the state's Early Intervention program of $1.145 million and $852,000 in new funding for the Birth Defects Program. These budget cuts continue to impact the ability of the Agency and the Bureau to perform its responsibilities and provide services to clients. Positions have been held vacant requiring staff to take on additional duties and the workload has not diminished. Since 2000 Health Services has decreased clinic sites by 15 or 14% going from 110 to 95 clinic sites statewide. The budget impact can also be seen below by the decrease in the number of clients seen by MCH staff in 2005 verses 2000.

Number of Clients Served 2005
Pregnant Women 7,963
Infants 24,603
Children 91,565
Children with Special Health Care Needs 6,959
Others 101,059
Total 232,149//2007//

/2010/ Significant budget cuts sustained in the previous year has resulted in reduced overall capacity of the agency. Critical decisions have been made regarding staffing and services to clients. Further cuts are anticipated in the upcoming fiscal year. //2010//

/2008/MCH continues to reduce the provision of direct services and increase enabling, population-based, and infrastructure-building services through increased involvement with partnerships and systems of care. Please reference Form 7 for unduplicated number of individuals served under Title V.//2008//

/2009/Please reference Form 7 for unduplicated number of individuals served under Title V.//2009//

/2010/Please reference Form 7 for unduplicated number of individuals served under Title V in 2008.//2010//

/2007/Programmatic and staffing patterns have been a focus of DHEC senior and MCH Bureau leadership over the past year. There should be much more progress to report here next year.//2007//

/2008/While the regional staffing situation has not improved significantly, regional budgets are somewhat more stable. There is no plan at this time for a reduction in force. In MCH, staffing has been impacted by changes in leadership as a result of new job opportunities and retirement. MCH has a new director who will be working with the Division Directors to maximize resources across MCH.//2008//

/2010/ The cumulative impact of the previous years state budget cuts has hit DHEC Regions hard, resulting in a significant lost of capacity within the Agency and the MCH Bureau.//2010//

/2007/Currently (2006) the South Carolina Medicaid Program is transitioning the care and oversight of its beneficiaries to health plans. Coincidently, the SC DHEC is experiencing significant restrictions in its ability to support core public health functions for the state's Medicaid beneficiaries. Increasingly these traditional services are being viewed as a health plan responsibility as opposed to a health agency responsibility. In order to continue to deliver these vital services and to be supported in doing so, DHEC will need to work with and in health plan arrangements and platforms. Since most MCOs have organic and internal mechanisms and resources to support their involvement in care coordination, case management and disease management, public health (DHEC) will tend to serve in a modest role with these organizations. The PCCM Model, however, allowed public health to be a full partner in these activities and access considerable resources to replace those that are being restricted. The primary care physicians involved in PCCMs will find that public health has considerable infrastructure and presence statewide to provide these support services. There are nurse case managers, advanced practice nurses, social workers, nutritionists and health educators in every public health region of South Carolina. Finally, the safety net function of public health as the "provider of last resort" can better be maintained by participating in this model.//2007//

/2008/Although the Medicaid agency has received increased funding, it continues to implement actions to promote cost savings. The restriction in the FSS contract resulted in a decrease of Medicaid earned funds. DHEC currently generates about one-fourth of the revenue that was generated by FSS prior to the 2005 restrictions. The Medicaid agency continues to promote managed care concepts in the state. After assessing the MHN (Medical Home Networks), formerly Primary Care Case Management Programs (PCCMs), the Medicaid agency decided to make some changes to the program that will result in changes in both formation of new MHNs and the organizational structure of the MHNs. In the latter part of 2006, the state prevented the formation of any new MHNs. Because of this, Community Health Solutions (CHS) will provide

administrative, fiscal and care coordination oversight for the Midlands MHN pilot. Two other changes have occurred in 2007. Currently, two Coordinated Care Service Organizations (CSOs) have contracts with the Medicaid agency for the development and management of the MHNs that operate in all but two counties in the state. Formerly, DHEC had a contract with Upstate Carolina Best Care (UCBC) to incorporate public health components into this MHN. Negotiations are currently underway for DHEC to develop a new contract with CHS to provide services "in the field". There are also four HMOs operating in the state. Please reference the "List of Managed Care Organizations by County in South Carolina" dated July 1, 2007, in the attachment. The other significant change is that the Medicaid agency has contracted with a vendor, Maximus, to provide Medicaid Enrollment Counseling Services. This process will be implemented regionally beginning August 1, 2007 and is scheduled for completion in February 2008. The Medicaid agency staff will continue to work throughout the state with Medicaid eligibility assistance. DHEC will continue to work with them on this effort.//2008//

/2010/Medicaid Managed Care's statewide automatic enrollment rollout was completed as of May, 2009. The number of beneficiaries who chose health plans was lower than expected (<70%). Six HMOs and 1 MHN remain. One HMO will cease SC operations in August. See attached "List of Managed Care Organizations." Quality measures have been added to MCO contracts to track quality of care and services. Input has been given to Medicaid and MAXIMUS (Medicaid Enrollment Vendor) through various DHECvenues.//2010//

/2007/The USC School of Medicine's University Specialty Clinics and SC DHEC proposed to establish and conduct a primary care case management network (PCCM) for the midlands of SC. This unique primary care practice health care delivery model will afford an opportunity for care coordination, case management and disease management to compliment overall health supervision, diagnosis and treatment. Medicaid beneficiaries who are already in the selected primary care practices will be afforded the opportunity to receive their care through this innovative public/private partnership practice model. The public health professionals involved in these activities will be supported from per member per month revenues received by the network. A smaller amount of the monthly sum will be available to the physician offices to accommodate their increased involvement with these processes. Both DHEC and USC bring strong community oriented primary care practices and philosophies that are extremely complimentary in their focus. The Midlands PCCM initiative will provide Medicaid beneficiaries the opportunity to obtain optimal health and well being within a health care delivery system that is a true public/private partnership. The key success factors include the strong existing presence and patient/client base of USC and DHEC in the midlands. Additionally, the approved DHHS PCCM model of primary care delivery offers a unique opportunity to support community oriented primary care and core public health functions as they focus on individual patients. The considerable existing infrastructure and resources of these two entities will help assure a successful launch of this initiative.//2007//

/2008/WCS continues to focus on improving access to adequate, affordable health care for children and CSHCN. Activities have continued to form a CSO for children and CSHCN through a collaborative and contractual relationship with USC School of Medicine (Educational Trust), Palmetto Health Children's Hospital, Family Connection, CHS (parent company for South Carolina Solutions [SCS]), Greenville Hospital systems, and the Medicaid agency. SCS-USC was officially created on October 12, 2006. Dr. Warren Derrick, former chair of the USC Department of Pediatrics, and Dr. Tan Platt, chair of the USC Department of Family Medicine, will serve as medical directors. SCS will assist with oversight, enrollment, configuration, assignment of levels of responsibility, and administrative logistics. They will also share in cost savings and disburse a per member per month reimbursement with the SCS-USC partnership. This will enable enhancement of services for vulnerable populations. A Physician Advisory Board will direct the CSO and will include public health members. In year 3 of the HRSA ICS Grant, funding was provided to SCS-USC to enhance the CSO. USC will hire a case manager whose responsibility will be setting up a case management system for CSHCN. Activities will include identification of CSHCN, enrollment, development of care plans, determining acuity level of care

and respective case management needs, and initiating a linkage to a community system responsive to identified needs. A parent with a CSHCN will serve on the Physician Advisory Board and family-to-family support will be provided. In this partnership, there is a strong emphasis on continuous quality improvement through the Institute for Health Improvement (Plan, Do, Study, Act [PDSA]) Model.//2008//

/2009/The USC/SCS MHN focused on CSHCN with 17 participating physician practices and 50,000 enrolled children is officially formed and recognized by Medicaid as a Medicaid MHN. A care coordinator, family support specialist and systems evaluator are in place.//2009//

/2010/ The USC/SCS MHN has a funded care coordinator and family support specialist. CSHCN have been identified and linked to certain diagnosis and anticipated levels of care coordination//2010//

/2007/The immediate needs are to establish an operational activity for the support services and identify 10,000 Medicaid beneficiaries who will be a part of this plan. Additionally, there will need to be an emphasis on developing clinical practice guidelines, best practices and care maps for various health supervision (health maintenance/wellness/prevention) activities and care of certain chronic and costly conditions. In addition it will be necessary to implement the care.//2007//

/2007/The increased Medicaid reimbursement for dental services in 2000 resulted in an increase in the participation of dentists with the program; however, without increases in reimbursements since 2000, the percentage of dentists paid for at least one dental Medicaid service has decreased from 54% in 2004 to 50% in 2005. Despite the decrease in the percentage of dentists in the Medicaid program, the percentag
An attachment is included in this section.

B. Agency Capacity

/2007/MCH provides a focus for DHEC Public Health Services (HS) Deputy area for priority setting/planning/policy development/administration of programs for MCH populations. MCH works with HS management to establish priorities/assure consistency in messages affecting MCH populations/assures integration of efforts across HS program areas/enables creative thinking to improve health outcomes/achieves state and national objectives for all women/children/youth/teens.//2007//

/2008/In 04/2007, Brenda Martin, RNC, MN, CNAA, was named new MCH Bureau Director. She has a long history of public health experience in various roles within DHEC and also has worked in the MC environment, bringing knowledge/skills necessary to facilitate continued collaboration with SC MCOs. MCH works closely across Public HS and HS Management to assure services are addressing data driven outcomes with best practices. Consistency across SC is critical to achieve MCH population outcomes. MCH and regional level staffing is at a very critical point. Defining priorities within priorities is necessary as DHEC continues to function with limited staff. Resignations and expected retirements will impact the MCH's ability to achieve desired outcomes.//2008//

/2007/The 2005 Strengths/Needs Assessment guides our mission of assuring the health and well being of women/children. Purpose is to disseminate credible information to the public/programs/stakeholders/policy makers to advance programs/enhance planning. MCH's role at the community/regional/state levels is to move away from the provision of clinical services and towards building/supporting/facilitating community health care systems through core public health assessment/assurance/policy development.//2007//

/2010/ Nathan Hale was named Assistant MCH Bureau Director in June.//2010//

Division of Women and Children's Services(WCS):

/2007/Access to quality FP is still a DHEC priority. As resources shrink, access at the same level is a challenge. Nursing staff is at a critical, all-time low. Between 2002 and 2004, DHEC lost more than 31% of its nursing work force. Working with an outside consultant, DHEC has identified services/practices to reduce/eliminate. For the 3rd year, open access clinic schedules, which offer same day or next day client appointments, are being used. The clinci no show rates using open access scheduling has decreased.//2007//

/2008/This past year continued to present DHEC with budget challenges as a result of increases in contraceptive costs and reduced allowable Medicaid billing. DHEC continues to operate with considerably fewer resources than in years past. During the 2006 legislative session, state funds were appropriated to DHEC to supplement the salaries for hard-to-retain employees. Approximate $2 million of these recurring state funds were allocated to nursing staff. Nursing staff providing direct services to clients received salary increases.//2008//

/2009/Contraceptive costs/staff shortages present challenges to the FP program. Nurses were hired and most regional caseloads are constant; but 2 health regions show a decrease in the number of clients served.//2009//

/2008/The 2004 teen pregnancy data indicates the rates have again begun to decrease after several years of remaining flat and DHEC's overall FP caseload appears at mid-year 2007 to be on the increase. The continuation rate for teens less than 15 seen in DHEC clinics is at 95% and for teens 15-17 is at 89%.//2008//

/2007/Mediciad PPNBHVs continue to make a + difference in newborn outcomes and are a cost-effective element of health care to this population. Nurses can identify infant problems early, such as poor weight gain, infant heart murmurs and blood pressure problems in the mother; help the family secure a medical home for the infant and stress the importance of well child care visits/immunizations. SC's target is for 90% of all Medicaid newborns to receive a PPNBHV within 3 days of discharge. In 2005, DHEC was able to provide visits to only 39.1% of this population. The shortfall is primarily attributed to DHEC's critical nursing shortage. See Organizational Structure for information on nursing retention and recruitment.//2007//

/2008/PPNBHVs underwent a detailed review by a statewide team. Medicaid increased the reimbursement rate for the visit and the leadership team reaffirmed DHEC's support of the visit as an MCH priority service. Policy changes directed at improving efficiencies and effectiveness have been instituted. Staff have made visits to each region to conduct supervisory visits and record reviews. The additional nursing staff will dramatically impact the ability to increase the numbers and timeliness of these critical visits.//2008//

/2009/High quality PPNBHVs remain a priority. While site visits and regional reports indicate policy changes have improved efficiency/effectiveness, reaching the SC goal of visiting 90% of all Medicaid newborns remains a challenge due to staffing limitations. The SC legislature earmarked funds to hire an additional 16 registered nurses. PPNBHV will increase when these positions are filled. Reducing infant deaths from SIDS and unsafe sleeping practices are major concerns. Based on the + results of a region's pilot, SC is increasing safe sleep educational efforts in PPNBHVs and current care standards for health care professionals in public health and delivering hospitals.//2009//

/2007/MCH has a long history of collaboration with the SDE. WCS has 2 employees who work across agencies to promote the health of school children. The School Nurse and School Social Work Consultants are responsible for working with the SDE to assure the health care needs of children are addressed. From the provision of ongoing screening and support of disease management to support for socio-emotional issues that impact learning and overall health, school nurses and social workers have public health infrastructure available to them. These 2 consultants assure a competent work force by providing ongoing consultation/orientation/training

to school staff. Recommendations/guidelines for policies/procedures are developed/provided to school administration. Linking the health needs of children to families/community resources/medical homes is needed if children are to be successful.//2007//

/2008/The School Nurse Consultant has brought together a collaborative of school health services leaders from local education agencies across SC to standardize student health care services. A listserv allows for discussions and a School Nurse Program Advisory Committee meets each school year to discuss school health services policies/procedures. In 2005, the Student Health & Fitness Act was enacted funding school nurses for elementary schools beginning with the 2007-08 school year. Within the 2005 legislative session, a law was enacted that requires Individualized Health Care Plans (IHCP) for CSHCN and implementation efforts continue. Partnerships help improve SC's infrastructure to support the health care needs of school-aged children and provide school nurses/school administrators with clear guidance regarding safe practices for student care. The School Nurse Consultant is an active member of the Board of Nursing's Practice/Standards Committee. The School Social Work Consultant works in collaboration between DHEC and SDE to bring opportunities to local school districts for more in-school social work services. DHEC received $250,000 from SDE to place public health social workers in 6 school districts specifically to address the unmet health/psychosocial needs of students who are identified as truant/chronically truant. This partnership has identified systemic issues that when resolved, can contribute to increased student health and attendance and more successful school outcomes.//2008//

/2009/See State Agency Coordination Section for school nurse consultant update.//2009//

/2008/The DOH/EdVenture partnership has been an opportunity to impact children's oral health. This formal agreement with the SC's Children's Museum integrates oral health materials/activities into the museum's community-based health promotion/disease prevention activities. EdVenture has also integrated the DOH information and "Activity Book for Afterschoolers" in their after school programs. Distribution of the SDE's Oral Health Curricula at their summer programs for teachers from high-risk schools is allowed. In school year 2005-2006, over 28000 students received preventive/full dental care through public-private partnerships.//2008//

/2007/DHEC has analyzed historical EPSDT data. A dialogue has begun over the EPSDT's future in SC and DHEC's role in providing well child health services. The gap has widened between the number of enrolled eligible children/number actually served. Non DHEC providers are seeing more children/provide more services per visit. These trends are likely to continue as DHEC concentrates on building infrastructure.//2007//

/2008/The MCH epidemiologist recently completed an evaluation of both the PPNBHV and EPSDT. These reports are not ready for final release. Because of the emphasis on building partnerships to impact practice improvement, less emphasis is being placed on EPSDT. A recent review of regional reporting indicates that only 1 county health department is providing very limited comprehensive well child care. As the Child Health Maintenance Course will not be provided this year, training can be targeted to the PPNBHV and ongoing updates for promoting regional collaboration with local partners and managed care.//2008//

/2009/SC's EPSDT eligibility/visit rate evaluation from 1998-2005 showed a 26% increase in children, birth-20, eligible for EPSDT. The number of services increased by 25%. Children 6-12 receive fewer well child visits. Teen visits are constant. DHEC provides EPSDT on a limited basis in Union County as a gap filler. DHEC promotes the medical home concept and expects to see visits increase in the private sector with more clients being assigned to MCOs.//2009//

/2010/ Most children covered by Medicaid and SCHIP are enrolled in an MCO and must choose a medical home within the MCO's network. DHEC EPSDT services have been phased out.//2010//

/2007/The purpose of the ECCS grant awarded 07/2005 is to support State MCH Agencies and their partner organizations in efforts to strengthen the State's early childhood system of services for young children and their families. The ECCS Planning Grant was written in collaboration with SC First Steps, a state level partnership of lead organizations promoting early childhood development. An Executive Committee includes key leader organizations for early childhood in SC such as: Office of the Governor, SDE, DMH, DDSN, DSS,
DHHS, Family Connections of SC, Inc/Family Voices, and SC Chapter AAP.//2007//

/2008/An ECCS continuation grant was awarded for 06-07. WCS will apply for the 3rd year of funding. In 01/ 2007, the ECCS Executive Planning Committee joined SC First Steps in the planning/implementation of the Governor's Summit on Early Childhood Education. Leaders from the SDE Early Childhood Division, DSS, Head Start, First Steps, and WCS led a panel discussion structured around school readiness and summarizing the current ECCS plans for systems growth. Further information is available in the "Summary of Readiness Growth Opportunities" table in the attachment. During the 06-07 ECCS grant year, there have been monthly meetings with stakeholders in 3 different groups with each group examining their current service system/exploring strategies that will lead to systemic improvement. The ICS grant's work groups serve as the stakeholder group for systems planning around Medical Home and Insurance issues.

/2010//ECCS received approval for the Implementation Plan in March of 2009. A DHEC/ECCS team applied for a SAMHSA Project LAUNCH grant.//2010//

There has been a strong push during this legislative session to expand 4-year-old kindergarten for all children who qualify for free and reduced lunch. Key Early Care/Education stakeholders meet regularly to develop a targeted early childhood 4K system.

The DOH is active in assuring infrastructure to support services for the young child. DOH developed and conducted an oral health component for the regional WIC training from 01-05/2006. A sample and order forms for the "First Birthday Card" were distributed which provides the parent/caregiver of a 1 year old baby with a toothbrush/instructions on how to use the toothbrush/recommendations for a 1st dental check. 13000 cards and toothbrushes have been sent to WIC programs throughout SC. DOH provided trainings throughout SC to childcare centers and Head Start educators. DSS approved the training, Oral Health 101 and Dental Emergencies Curriculum, for use in the licensed child care programs. The DOH has sponsored 2 Train-the-Trainer programs, one at EdVenture and the other at the State Head Start Conference.

DHEC has refocused efforts on developing private/public partnerships as the health department provides fewer direct services. The combined efforts of the ICS grant and the CATCH meeting have focused on a more targeted approach to partnerships/systems development. DHEC has broadened its range of partnerships by actively recruiting partnerships with Family Practitioners and FQHCs in addition to the traditional pediatric and OB/GYN partners. DHEC has integrated the Medical Home Advisory Board into the Commissioner's Pediatric Advisory Committee (PAC) to better utilize physician time/efforts. The PAC's purpose is to assist/advise DHEC's Commissioner on issues impacting pediatric/adolescent health in SC. The group is comprised of pediatricians representing the varied geographic areas of SC, pediatric sub specialists, family medicine practitioners, the Medicaid agency, Family Connection, USC School of Medicine faculty, and the current chair of the SCAAP Chapter. This group routinely addresses immunizations, newborn hearing and metabolic screening, birth defects registry, Medicaid changes, and other issues as needed. This group will serve on a stakeholders committee to look at the Title V CSHCN Program and will work closely with First Steps to integrate a medical home approach into the First Steps community efforts.//2008//

/2007/Families should receive ongoing comprehensive care within a medical home that connects families with a primary care provider and wrap-around public health services, such as social work/nutrition/nursing/health education. DHEC has been moving down the MCH pyramid and

developing partnerships with private/public providers. The number of partnerships has decreased over the past year.//2007//

/2009/MCH still focuses on partnerships and plans to attend events/conferences through which its partners receive ongoing training. The PAC provided input for the proposed changes to the Title V CSHCN Program and will provide consultation for potential opportunities to enhance medical homes.//2009//

/2010/ The Medical Home Team (MHT) has been reconvened. This group has met and is exploring options to collaborate with managed care on quality improvement issues.//2010//

/2007/An evolving clinical practice platform allows a focus on overseeing/delivering health care within the context of community/public health/primary care medical practice. The primary care case management model supports care coordination/case management/disease management at the physician practice as opposed to the health plan level. There is considerable emphasis on integrating core public health functions and utilization of community strengths/assets to maintain/improve the health of local populations. PCPs are funded to integrate these concepts into their practices. MCOs use a portion of their premium to conduct these services. Many are done at the health plan level using the telephone as the primary conduit for communication. MCOs work with physicians in these activities but the degree of physician involvement varies widely. The PCCM Model assures physician oversight/integral involvement in these community-oriented processes that have demonstrated improved outcomes.

MHNs, formerly known as PCCMs, are the Medicaid agency's MC options for children that have expanded throughout SC. MHNs operate in almost all of the 46 SC counties and staff have established relationships with them. DHEC has extended its contract with 1 of the MHNs to develop/maintain the public health component, focusing care management on asthma/diabetes. To integrate effective public health practices for CSHCN into MCOs, MCH is working with USC to develop a MHN for the midlands area. DHEC staff works with other MHNs to assure that children, especially CSHCN, have access and address any concern regarding the effect of differing health policies/procedures on service delivery systems.//2007//

/2008/DHEC staff has developed relationships with the MCOs and provide periodic updates to staff regarding recent developments within Medicaid and MC arenas. Updated MC provider lists assist staff with forming/maintaining relationships/partnerships with various providers in their local areas. DHEC worked with providers and the Medicaid agency to address systematic issues including the lack of specialty providers and clarification on authorization guidelines. Staff work to keep all programmatic/billing staff current on policies/ guidelines. The 2 areas work together to address the growing concern of authorizations for services. CRS is still experiencing difficulty obtaining identification numbers from pediatric subspecialists due to interpretations of privacy laws. These numbers are needed to improve billing efficiency.//2008//

/2010/ DHEC continues to focus on relationships with MCOs. DHEC staff has met with the HMOs for contract negotiations and discussed services and resources.//2010//

/2009/DHEC maintains/improves upon relationships with MC organizations. Staff meet with the newly formed HMOs to discuss services/resources and receive updated information on SC MC activity. MCH works with providers and DHHS to address systems issues.//2009//

/2007/ This is the 2nd year of ICS, designed to improve health care systems for children, including CSHCN. 2005 partnership activities include:

Linking and Aligning Mental Health and Primary Care: Contract being developed between DHEC and Beckman Center, DMH, for a pilot project to co-fund mental health counselors at Montgomery Center for Family Medicine and Greenwood Community Children's Center

Co-Sponsorship of a Youth Leadership Forum with SC Partners in Transition, including representatives of multiple agencies and colleges

Contracts developed with Federation of Families and PRO-Parents to provide training on educational/behavioral components of transition for youth/parents/professionals.//2007//

/2008/See the Overview for ICS grant details.

FSS continue to decrease in number/type, but are a continued need. The majority of FSS now are nutritional services. DHEC is exploring ways to provide FSS within the guidelines of MC and with limited staff.//2008//

/2009/DHEC is exploring ways to provide needed FSS, which continue to primarily focus on nutrition.//2009//

/2010/ FSS continues to focus on nutritional needs. DHEC staff met with MCOs in contract negotiations to promote inclusion of FSS in MCO contracts.//2010//

/2007/Through newborn screening, all infants are tested at birth for certain disorders that cause mental retardation, abnormal growth and even death. SC's screening test panel is one of the most comprehensive in the US. Early diagnosis leads to early interventions that improve the infant health.

/2010/ No change //2010//

CDC funding for Lead Screening ended 06/2006 and activities in the central office will change related to the statewide database. Contracts with consultants and BEH will not be continued, though BEH will still provide services for environmental investigations.//2007//

/2010/ No change //2010//

/2008/In 06/2006, Newborn Hearing Screening was moved from the CSHCN Division to WCS. To better coordinate surveillance systems, this puts First Sound (FS) in the same Division as newborn metabolic screening. State law requires newborn hearing screening for all infants born in hospitals with 100 or more annual births. All SC birthing hospitals provide newborn hearing screening regardless of the number of births.//2008//

/2009/All SC birthing hospitals continue to provide newborn hearing screening regardless of the number of births.//2009//

/2010/ The First Sound Program has been successful in developing a web-based system that allows the integration of program data with vital records.//2010//

Division of CSHCN:

/2007/Newborn Hearing Screening (NHS): State law requires NHS for all infants born in hospitals with 100 or more annual births. FS works with these hospitals to assure compliance with the law and accurate reporting. SC funds defray hospital costs associated with NHS and reimburse audiologists who provide follow-up services for children with no other pay source. HRSA/MCHB/CDC grants support FS follow-up services/data systems. Congenital hearing loss, if undetected at birth, can cost the education system approximately $420000 per child in special education services over the 12 years of education. FS is charged with screening infants by 1 month of age/have a confirmed diagnosis by 3 months of age/receive early intervention by 6 months of age if hearing loss is identified.//2007//

/2008/NHS moved to WCS in 06/2006. See update in WCS Section, Section C.//2008//

/2010/ Key priorities for the coming year include web site revisions, ECCS State Implementation Plan, collaboration on the ACF Home Visitation Grant, Nurse Family Partnership, Help Me Grow, the SC Oral Health Advisory Council/Coalition, and potentially the Project LAUNCH grant.//2010//

/2007/FY07 priority for CSHCN Division is a comprehensive statewide assessment of current programs/resources/ stakeholder opinion about priorities given decreasing resources/Title V expectations. Assessment will be conducted over 12 months starting 07/2006 in 4 phases under the leadership of the CRS Program Manager and the Division Director which includes self-assessment of regional and central office current activities/strengths/ weaknesses/opportunities and threats; assess role of current/potential partners to ensure a comprehensive/ integrated system of care; develop a CSHCN mission/vision/strategic plan/implemenation plan. Division and Bureau level managers have identified the need for a complete assessment of CSHCN programs. Decisions about resouce allocation changes have been delayed until completion of assessment.//2007//

/2008/The comprehensive needs assessment for FY07 was started with information gathering visits conducted by the CSHCN Division and Assistant Directors to regional staff/providers/statewide family support and advocacy groups. Activity has been postponed in light of MCH/DHEC concerns related to increasing cost of direct care programs supported with block grant funds, primarily CRS, and exhaustion of other funds to subsidize the program. There is agreement on expenditure limits for this program and next steps. With input the following priorities have been established for the Division dependent on available state/federal funding:
1.Filling key positions that have been vacant for a while. These positions are required for planning/
implementation of any activities other than maintenance of existing programs with no changes. They include: Division Nurse Consultant; Data Coordinator; CRS Program Manager; Parent Support and Transition Statewide Consultant; and Senior Program Manager for oversight of Division direct care services.
2.Obtaining stakeholder input regarding specific CRS program changes to reduce expenditures to level in line with available funding.
3.Completing needs assessment activities, and based on findings and with stakeholder inputing/redefining/ clarifying CSHCN Division activities and priorities over the next 5 years. CSHCN will focus upon training/ consultation/TA regarding best practices in delivery/financing of services for the entire target population.
Current (and historic) CSHCN Division activities/initiatives focused on purchase of services/equipment for children meeting specific eligibility requirements. Expansion of the range of Division services can come only after these programs are operating efficiently/fully within funding limitations.

Previous applications have referred to "the state CSHCN program" and that "most services for CSHCN are housed in the Division of CSHCN." Currently Title V supported services for CSHCN are operated out of 4 of the 5 MCH Divisions. Planning/implementation/evaluation of these services are done collaboratively as indicated below:

a) WCS: ICS Grant to improve services to CSHCN, including transition to adulthood, and ECCS grant activities targeting all children 0-5, including the subset of CSHCN and NHS and Follow-Up

b) DOH: CDC funded activities to improve dental services for CSHCN

c) Division of Perinatal Systems: Birth Defects Registry

d) CSHCN Division: CRS, Medicaid gatekeeper services for hearing aid and cochlear implant supplies and orthodontia, IDEA Part C early intervention services. For services housed in the CSHCN Division (excluding IDEA Part C), current staffing is sufficient for maintaining day-to-day

operation of direct care program as listed. Given expenditure/revenue trends this decade, in SFY06 expenditures for payment of services authorized through the CRS program substantially exceeded available funding. This shortfall affected activities in FFY06 (past year), FFY07 (current year) and plans for next year. Implementation or continuation of activities necessary to begin expansion of Division activities beyond direct care services has been postponed pending resolution of the CRS program budget shortfall. Longstanding vacancies remain unfilled. Work related to planning or implementing any activity that would divert resources from covering the cost of CRS programs has been put on hold pending development/implementation of a permanent reduction plan of CRS program costs in the fiscal year beginning 07/01/2007. A specific spending limit has been established following analysis of program expenditures. During the 1st quarter of SFY08, policy changes will be identified to assure that expenditures do not exceed this limit. Those decisions will be made with broad stakeholder input to begin with a "town hall meeting" in 08/2007. Please reference attached table, "Framework for Rebuilding Division of CSHCN Programs."//2008//

/2009/In SFY08, assessment/planning of Division services/priorities continued. Input was received from numerous public/private sector and CSHCN family stakeholders during public forums held 02/2008 and 06/2008. DHEC will make a final decision on decreased services available through CRS. These changes will reduce expenditures to match available funding. BabyNet is implementing revised policies 07/01/2008 to narrow eligibility guidelines. 3 key positions are vacant: Division Nurse Consultant, CRS Program and Business Managers. The data coordinator position was filled 01/2008 and the assistant division director 02/2008. Availability of accurate/reliable data for CSHCN management decisions is critical. A broad assessment of division data needs for all programmatic areas will be completed early SFY09. Current data systems capabilities/other possible solutions to data needs will be explored. CSHCN populations are served through the CSHCN Division and through various MCH programs and activities. Decreased program expenditures and staff recruitment for key vacant positions will be the focus for SFY09. A broader CSHCN population focus at the regional level will continue. Meetings with regional management staff will provide updates on the future direction of division programs and outline expectations for regionally funded CSHCN staff. The regional CSHCN allocation method will be reviewed. Meetings with the 4 SC children's hospitals for coordinated assessment/planning of pediatric subspecialty care and related CSHCN population needs will continue. The Division Data Coordinator will play a key role in assessment/planning/implementation/monitoring of CSHCN populaton data.//2009//

/2010/ Changes were implemented as part of a long-term plan for restructuring in order to assure sustainability of key services for CSHCN. Clinic-based services provided in urban areas decreased, while limited expansion of these services occurred in rural areas with increased need and lack of access to pediatric sub-specialty providers. Planning is underway to adapt current infrastructure to capture CSHCN data in a new format. BabyNet continues to face challenges in reducing expenditures to match available funding. The governor's office explored the feasibility of a lead agency change for Part C. Increases in SC Medicaid rates for therapy services resulted in increased expenditures and increased utilization of therapy services. //2010//

Division of Perinatal Systems:

/2010/The Birth Defects, FIMR and Perinatal Regionalization programs moved to the new Research and Planning Unit. The Care Line and the Sexual Assault Prevention programs were moved into Women's and Children's Services (WCS).//2010//

/2009/Perinatal Regionalization has worked well since 1985. MOAs are established annually between the Perinatal Centers and the 4 regional hospitals. MC is posing barriers to continued Regionalization success. Perinatal Centers are not contracting with all of the 7 SC MC companies negatively impacting the formerly seamless referral/transport/transfer system. With strong support/collaboration from the SC Hospital Association, Regionalization effectively distributed

videos/materials regarding the new Shaken Baby law.

/2010/No Change.//2010//

The Care Line (CL) is the toll-free number for Title V. Handling some 14000 calls per year, staff also exhibit at health fairs/other community functions. Information about pregnancy/well-baby care/medical providers is distributed. All information is available in Spanish. 2 CL staff speak Spanish and Hispanic calls are increasing as SC's Hispanic population grows. The CL distributes the Caring for Tomorrow's Children book that teaches about pregnancy and the first year of life.//2009//

/2010/ In 2008 the Care Line fielded 17, 056 calls.//2010//

/2007/Disorders relating to premature/LBW babies are among the leading causes of infant deaths. 524 babies born to SC women during 2004 died before their first birthday. SC's infant mortality rate is 9.3 per 1000 live births compared to 2003's rate of 8.3 and 9.3 in 2002. Deaths to racial/ethnic minorities at a rate of 14.7 per 1000 live births continue to be more than twice that of white babies at 6.4 The leading cause of death in 2004 for SC infants was congenital malformations. Data confirms that babies are being born too early/too small, many without adequate prenatal care. Pregnant women can improve their unborn baby's health by planning their pregnancies/being sure they are healthy before a pregnancy. Risk factors rise for poor pregancy outcomes if maternal complications are not under control before/throughout the pregnancy. Strategies to combat infant mortalitiy are constantly being evaluated/must be based on sound science.//2007//

/2009/SC's Safe Sleep campaign works with the PPNBHV program. Nurses use a toolkit with AAP's tips for safe sleep. An FIMR database will provide information about SC fetal/infant deaths. FIMR is convening a statewide group quarterly to provide policy guidance/development and plans to include a Maternal Mortality Review.//2009//

/2010/Progress towards convening a statewide FIMR team have been slowed due to ongoing budget reductions and loss of capacity. The Understanding Shaken Baby Syndrome DVD has been completed and is in the process of being distributed.//2010//

/2008/In 2005, the leading causes of infant deaths were congenital anomalies, prematurity, maternal complications and SIDS. Chronic medical conditions like HTN, diabetes and obesity were also found in women who experienced losses. Smoking during/after pregnancy has also been found in women who have experienced a loss. Greater than 50% of all pregnancies were unplanned and a large number of women continue to have late entry into prenatal care.

Through the FIMR Community Action Process, several SC initiatives are being developed/initiated to assist in improving infant mortality rates. A SC Safe Sleeping Campaign is being developed through collaboration with a wide array of agencies/providers. A nursing education forum is being planned with the assistance of First Candle to address the need for nurses to model appropriate safe sleeping behaviors while caring for newborns in SC's nurseries and NICUs. Safe sleeping videos have been developed and are being disseminated statewide. A statewide, web-based FIMR database will also be implemented/coordinated with DHEC's Vital Records Division. At the local level, all regions continue to assess their FP Services, access to/early entry into prenatal care to increase the chances of a healthier pregnancy. Using the FIMR process to continually monitor/review/assess is helping DHEC develop strategies to improve SC's infant mortality rates.

Bill S. 518 passed in the SC Legislature requiring hospitals to make available to the parents of a newborn a video presentation on the dangers of shaking infants and request that the primary caregiver view the video. See Other Program Activities, Legislation Section for more details.//2008//

/2007/There is a strong connection between sexual assult/domestic violence which remains a major SC public health concern. Of the people who reported sexual violence, 64% of women and 26% of men were raped, physically assaulted or stalked by an intimate partner. There were 39803 reported domestic violence cases in 2002 and 35595 cases in 2003. SC Coalition Against Domestice Violence and Sexual Assault reports that 4400 women/children were sheltered and 33785 hotline calls were answered in 2003. PRAMS reports 3.6% of white and 8.4% of black respondents indicated they were physically abused during pregnancy. In 2004, 1720 cases of forcible rape were reported to law enforcement in SC. The state's 16 sexual assault centers served 647 new pts. //2007//

/2008/MCH continues to observe an alarming trend in connection with sexual assault/domestic violence. There were 52420 reported cases of domestic violence in 2005. The SC Coalition Against Domestic Violence and Sexual Assault reports that 4314 women/children were sheltered and 26476 hotline calls answered in 2005. In 2005, there were 1825 cases of rape reported and the sexual assault centers served 4990 new clients.//2008//

/2009/MCH still reports high numbers of sexual assaults/domestic violence incidents. 35054 cases of domestic violence were reported in 2006. The SC Coalition Against Domestic Violence and Sexual Assault reports 4318 women/children were sheltered and 18830 hotline calls answered in 2006. In 2006, 1810 cases of rape were reported and the sexual assault centers served 4990 new clients.//2009//

/2010/ SC DHEC reports 4884 direct victims and 2,970 secondary victims of sexual assault were served by local rape crisis centers. State budget cuts have reduced the capacity for services.//2010//

/2008/The Division of Perinatal Systems implemented the South Carolina Birth Defects Program (SCBDP). Funded in 07/2006, this program is developing a system of active surveillance of major structural birth defects occurring in SC. The SC Birth Defects Act of 2004 established the SCBDP within DHEC. It states DHEC shall promulgate regulations necessary to carry out active surveillance of birth defects, reporting, service linkage and other provisions of the Act. SCBDP staff initiated the state regulations process. The Notice of Drafting was filed with State Registrar and published in the State Register on 05/25/2007. Hopefully the draft regulations will be approved by the SC Birth Defects Advisory Council in July after which they will be sent to the DHEC Board for the next step in the process. The regulations promulgation schedule developed in conjunction with DHEC's Manager of Regulation Development plans ultimately for provision of the proposed regulations to the Legislature in 01/2008. The SCBDP has been in the process of hiring staff, transitioning birth defects monitoring from Greenwood Genetic Center, developing/implementing an electronic data system, forming a system of referral/linkage, and establishing the a statewide Birth Defects Advisory Council. Surveillance has been expanded and includes limb defects, neural tube defects, cardiac defects, and orofacial clefts. The purpose of SC birth defects surveillance is to determine rates/trends of birth defects; promote efficient/effective referral of infants/families for appropriate services; develop public health strategies for the prevention of birth defects; and conduct research into the causes/distribution/prevention of birth defects. Trained nurse abstractors are collecting birth defects data in hospital/other medical settings. The SCBDP will ultimately expand the scope/capacity of birth defects monitoring with the long term goal to include all major birth defects identified prenatally through age 2.

As the SCBDP data system is just being completed, DHEC will have no data to report until 2008. National data indicates structural birth defects have emerged as the leading cause of infant mortality in many developed countries. Currently in the US, birth defects account for 20.7% of infant deaths, exceeding deaths from prematurity/LBW, SIDS and respiratory distress syndrome. Major birth defects have been found in 2-3% of live born infants and 15-20% of stillborn infants. By age 5, 4-5% of children will be found to have major anomalies. Minor anomalies occur in

much larger numbers. SC Vital and Morbidity Statistics (2001) indicate infant mortality rates from birth defects in SC are higher than the national average. Although structural birth defects affect less than 5% of all live births, they contribute disproportionately to morbidity and long-term disability and to fetal/ infant/early childhood mortality. The etiology of structural anomalies is poorly understood with up to 70% of cases unknown. Causes can include chromosome aberrations, single gene mutations, environmental insults, and multifactorial causes. The economic impact is massive. Most infants with birth defects survive and disproportionately consume health care resources. Birth defects are responsible for 25-30% of pediatric hospitalizations. Successful strategies to prevent birth defects have been developed in recent decades and data gained from birth defects surveillance systems help speed the pace of new discoveries.//2008//

/2009/The SCBDP is in its 2nd year. After a 1st year of surveillance of 19 types of birth defects (BD), in 01/2008 the remaining 26 BD categories recommended by the National BD Prevention Network were added. Nurse abstractors based in 3 of 4 Perinatal Regions collect BD data in hospitals. A 5th Nurse Abstractor is being recruited to include outpatient cases. SCBDP regulations were approved by the SC Birth Defects Advisory Council (BDAC), DHEC Board and SC Legislature. The SCBDAC which provides oversight/support to the SCBDP convened the Data and Research Committee (DRC) to obtain vital input regarding data reports/analysis/future needs. DRC will develop a system to screen requests for data research use. After 07/2008, DRC will report on the initial 19 BD categories monitored. Over 1000 cases were abstracted. SCBDP developed a state-of-the-art electronic data system linked to DHEC newborn screening systems to monitor SC children with BD and enhance prevention.//2009//

/2010/ The Birth Defects Program (SCBDP) has expanded surveillance to all categories of major structural birth defects recommended for monitoring, gained remote access to medical records in 14 hospitals, and set up a referral network with BabyNet.//2010//

Division of Oral Health:

/2008/DOH has focused on developing stronger public health infrastructure. Once the structure for the Advisory Council and Coalition was improved, improvements on the State Oral Health Plan (SOHP) have been moving forward with much greater momentum. The current version addresses seven key areas, as recommended by the Advisory Council and Coalition, including: 1) advocacy/policy, 2) surveillance, 3) fluoridated water, 4) social marketing, 5) workforce, 6) chronic diseases, and 7) special populations. Special populations include early childhood (preliminary), CSHCN and public school children (school based sealant program).

The CSHCN section of the SOHP was developed through funding received from ASTDD beginning 04/2006. This planning group included DOH staff as well as representatives from BabyNet, CRS, Family Connection of South Carolina, Medicaid agency, Head Start Collaboration Office, SC Dental Association, SC Dental Hygiene Association, DDSN and the SC Rural Health Research Center at USC. The comprehensive planning document is available at http://www.scdhec.gov/health/mch/oral/index.htm.

DOH has contracted with a USC Arnold School of Public HealthResearch Assistant to expand the DOH Surveillance Plan to include both the qualitative/quantitative data required for evaluation of the SOHP. DOH and the School Sealant Evaluation Workgroup is working with the BCB's ORS to develop a unified data collection instrument for DHEC's School Dental Program. This will allow the data to be linked with other data stored at ORS such as the SDE, Medicaid, etc. A comprehensive plan for an Oral Health Needs Assessment for students in K-5 and 3rd grades has been developed using the Seven Step Model of the ASTDD. Implementation is ongoing. D

/2009/Over 5700 children were screened using the OHNA Basic Screening Survey. DOH is analyzing the data and anticipates submitting the report to NOHSS by 09/2008. The OHNA 2007-2008 will provide DOH a current assessment of untreated dental caries/dental treatment

urgency/presence of dental sealants. This data will be used to target future resources for school-based sealant program expansion.

DOH's Education Consultant developed many oral health curricula including SDE-sponsored materials for public school use and a corresponding parent information booklet used in child care centers/preschools. The State Superintendent of Education appointed her to the SDE Health/Safety Standards Review Committee.

See DOH Staff Activities/Presentations' Attachment.//2009//

/2010/The Oral Health Division developed prenatal guidelines for oral health and pregnant women entitled South Carolina Takes Action: Oral Health for Pregnant Women, to be distributed to providers across SC.//2010//

/2010/ The DHEC School-based Dental Prevention Program served over 23,000 children in 412 schools throughout the state (2007-2008).//2010//

/2010/DHEC successfully partnered with the South Carolina Dental Association and the Columbia Marionette Theater in the production of a 20 minute interactive puppet show that has reached over 6900 to date.//2010//

WIC:
/2009/ The CARES WIC module, though functioning well overall, is still slow, . A problem with information disappearing/appearing in a client's record that should have been in a previous record visit is being resolved.
The new WIC food package including fresh fruits and vegetables will be a great benefit to recipients.//2009//

/2010/The WIC Program is currently implementing the USDA mandated new food package which aligns foods offered in the WIC Program with the Dietary Guidelines for Americans and infant feeding practice guidelines of the AAP.//2010//

/2010/The WIC Program is developing an on-line web-based nutrition education system that will be linked to the WIC CARES data system.//2010/

C. Organizational Structure

/2007/The General Assembly created the SC Department of Health and Environmental Control (DHEC) in 1973 when it reunited the State Board of Health and the Pollution Control Authority. The agencies mission is to promote and protect the health of the public and environment. The agency is under the supervision of the Board of Health and Environmental Control, which has 7 members, one from each congressional district and one at large. The Governor, with the advice and consent of the Senate, appoints members.

In 2005, DHEC consolidated 12 district offices into 8 regional offices. This streamlined administration and improved efficiencies. The move should generate cost savings, increase accountability and renew the agency's focus on customer service.

DHEC operates local health departments and clinics to ensure that the many programs and services we provide will meet the needs of local areas. The central office is located in the state capital, Columbia. DHEC's total budget for fiscal year 2006, including state, federal and other funds, was $530,805,287

The Bureau of Chronic Disease Prevention and Home Health Services has been renamed to Community Health and Chronic Illness Prevention.

Current organizational charts are included in the Appendix.

The training and retention of staff are key issues for DHEC. Training needs are assessed by unit, program and discipline. There are numerous opportunities for staff to improve in a number of different competencies.//2007//

The organizational structure for Public Health Services have, for the most part, remained the same over the past year. Additions are noted in the "key leaders" section that follows.

Organizational charts for the 5 divisions in MCH are in the Appendix.//2007//

/2008/Please reference updated organizational charts in the attachment .//2008//

/2009/Please reference organizational charts in the attachment.//2009//

/2010/Please reference organization charts in the attachment.//2010//

/2010/A Research and Planning Unit within the Bureau has been established under the direction of Asst. Bureau Director Nathan Hale.//2010//

Following are brief biographies of key leaders within MCH in DHEC:

/2008/ Dr. Harvey Kayman left the Bureau in November 2006. //2008//

/2008/ In April 2007, Brenda Martin, RNC, MN, CNAA, was named new MCH Bureau Director. Ms. Martin has 24 years of public health experience in various roles within the agency. Her last two positions prior to this appointment were Regional Director of Nursing and Associate Director of the Division of CSHCN. She also has worked in the private sector in the managed care environment, bringing knowledge and skills necessary to facilitate continued collaboration with managed care organizations within South Carolina. //2008//

/2008/ Candace Jones left the Bureau in May 2007. //2008//

/2007/David H. Lees, DDS, JD, MBA: MCH Program Coordinator. He has been with the SC MCH Bureau since September 2005. He has experience working with at risk children. He has been identified as the coordinator for Bureau planning and the MCH Block Grant.//2007//

/2008/David Lees left the Bureau in 12/2006.//2008//

/2007/Nathan Hale, the lead MCH Epidemiologist began on June 19th. Nathan recently worked in TN as a Public Health County Director and as an Epidemiologist. He has a MPH with an emphasis in Community Health Education from the University of Tennessee in Knoxville.//2007//

/2008/ Nathan Hale will be leaving full time employment in 06/2007 but will remain in an hourly position for the immediate future. //2008//

/2009/Nathan Hale will be Assistant MCH Bureau Director effective July 1.//2009//

/2007/A Graduate Assistant (GA) will be hired to support Block Grant activities through a contract with the USC Arnold School of Public Health.//2007//

/2007/Epidemiology GA: A post-doctoral GA will be hired to support Block Grant epidemiology activities through a contract with the USC Arnold School of Public Health.//2007//

/2008/MCH continues to work closely on a shared research agenda with the USC Arnold School of Public Health. A post-doctoral Graduate Assistant may be hired in 2008.//2008//

/2008/The DOH hired a full time employee to fill the School Dental Coordinator Position.//2008//

/2010/ Wesley Gravelle was hired as the MCH epidemiologist.//2010//

Division Directors

Sarah Cooper, RN, MN, CS: Director, Division of WCS. Sarah Cooper has over 25 years of nursing and management experience with DHEC, with positions at county, district, and state levels. She is the agency team leader for medical home partnerships and oversees the new Medicaid managed care product entitled 'Primary Care Case Management (PCCM)' pilot program.

/2008/ Sarah Cooper retired in June 2007 but will be providing some consultation on an hourly basis for the immediate future.//2008//

/2009/Janet Sheridan was Interim Director of the Division of WCS for the past year. Effective 07/02/2008, Lucy Gibson will serve as Division Director.//2009//

Cheryl Waller, BSN, MPH, Director, Division of CSHCN. Ms. Waller joined DHEC in April 2005 from NC. She also has over 25 years of nursing and management experience at the state and federal levels.

Burnese Walker, MS, RD: Director, WIC Program. Burnese Walker has over 20 years experience working with WIC programs in two states (GA and SC). She has also worked with School Food Services at the SDE.

Luanne Miles, MSW: Director, Division of Perinatal Services. Luanne Miles has worked with MCH programs at DHEC for the past 10 years. Previously, she worked as a clinical social worker with children and families for 11 years in both private and public health agencies.

/2007/Kathy Swanson, MEd: Director, Division of Perinatal Systems. She was promoted into this position in 12/2005 after 13 years with DHEC. She was the BabyNet Program Coordinator from 1997 until she became the FIMR Director in 2000. Ms. Swanson provides leadership for the development and maintenance of systems of care that assure access to perinatal services and promotes improved maternal and infant health.//2007//

/2008/ Kathy Swanson now also serves as DHEC's appointed representative on the State Child Fatality Committee. //2008//

/2010/ Perinatal Systems Division Director Kathy Swanson retired effective January 16, 2009. //2010//

/2007/Christine Veschusio: Director, Division of Oral Health. Ms. Veschusio was appointed the Director of the DOH in 02/2006. She has been with the DOH since October 2002. Her responsibilities include the oversight of the school dental prevention program, provide input, technical assistance and recommendations to the Bureau and Agency staff and leaders, policy-makers, legislators, Board Members, Oral Health Advisory Council and Coalition, and community groups related to the state's public oral health needs and programs.//2007//

Other Key MCH Staff

Janet Sheridan, MA: Director, Family Planning Program. Janet Sheridan has been with DHEC over 20 years. She previously served as Division Administrator, returning to the Division of WCS in 2000 as Family Planning Director. She has a broad background in fiscal operations and contract development and auditing and holds the designation as a Certified Public Manager. Her

MA is in Conflict Resolution, and she is called upon frequently to apply her skills both internally and externally.

/2007/Brenda Martin RNC, MN, CNAA: CRS Program Manager, Division of CSHCN. She has been with CSHCN since 10/2005. Her responsibilities include coordinating activities to assure access for children with special health care needs. Ms. Martin has over 20 year's leadership experience in public health at the county, regional and state level in SC. She currently serves as Vice President of the SC State Board of Nursing.//2007//

/2008/ Brenda Martin is now the MCH Director.//2008//

/2009/Leanne S. Bailey, RN, joined the Division of CSHCN in 02/2008 as Assistant Director. She brings over 20 years experience with CSHCN at the regional level in service delivery and program management.//2009//

/2007/Kathy Tomashitis, MNS, RD: Program Manager, Pediatric Screening, Division of WCS. She has directed the newborn metabolic screening program, childhood lead poisoning prevention program and congenital syphilis follow-up program since 09/1994. Prior to that time she was a nutrition consultant for children's services.//2007//

/2007/Lucy Gibson: State Adolescent Health Coordinator. In this position, Ms. Gibson works to establish and sustain partnerships and connections with other adolescent health programs within and outside of the agency, and facilitate the exchange the knowledge of adolescent health across the state and nationally.//2007//

/2008/Lucy Gibson supervises the newly-formed Community and Partnership Team in WCS. This team's key roles include writing, implementing, monitoring, and evaluating grants and contracts, and establishing and maintaining partnerships related to the health needs of women, children and families. Ms. Gibson also serves as lead contact for domestic violence.//2008//

Sandra Jeter, LISW. Lead contact for youth suicide prevention and domestic violence, and serves as DHEC's representative on the CDC Healthy Schools Infrastructure Grant. Sandra Jeter is located in the Bureau of Community Health and Chronic Disease Prevention.

/2008/Sandra Jeter, LISW: Ms. Jeter continues her work with the CDC and Healthy Schools Infrastructure Grant.//2008//

/2008/Mary Kelly, MSW, is now the lead contact for youth suicide prevention.//2008//

/2008/Amy Nienhuis, MSW, LISW, joined the Division of Perinatal Systems as the FIMR Coordinator 12/02/2006.//2008//

/2009/Amy Nienhuis resigned from Perinatal Systems in 04/2008.

/2010/ Breana Lipscomb joined the Bureau as the FIMR coordinator//2010//

See attachment in Agency Capacity Section for DOH key staff.

The SC Birth Defects program has hired Kate Clarkson, MD, as geneticist consultant, Jihong Liu, Sc.D. as Epidemiology Consultant, and Alexa Gallagher, MPH, Epidemiology Graduate Assistant.//2009//

/2010/ The geneticist and epidemiology consultant positions were eliminated as part of state budget reductions.//2010//

/2007/FTE positions within Health Services Central Office that work with the MCH population

include:
Managerial/administrative/budget: 29
Administrative Support: 23
Program Director/ Manager: 20
Nutritionists: 4
Social Workers: 6
Health Educator: 4
Nurses: 6
Data and Research Managers: 7
Total: 99, of which 8 are in Health Services Administration//2007//

/2008/FTE positions within Health Services Central Office that support the MCH population include::
Managerial/administrative/budget: 30.9
Administrative Support: 14
Program Director/ Manager: 13.7
Nutritionists: 3
Social Workers: 3
Health Educator: 1
Nurses: 7
Data and Research Managers: 8
Total: 80.6
Numbers of positions continue to decrease due to budget cuts. It is difficult to calculate a vacancy rate because when a position is vacated, there is a rigorous process in place through the Health Services' Position Approval Team to determine whether or not it can be refilled. It is likely that many of the vacancies in MCH will never be refilled, thus additional key duties are assigned to existing staff.//2008//

/2009/FTE positions within Health Services Central Office that support the MCH population include:
Managerial/administrative/budget: 30.6
Administrative Support: 13
Program Director/ Manager: 13.9
Nutritionists: 2
Social Workers: 3
Health Educator: 1
Nurses: 7
Data and Research Managers: 7
Total: 77.5
Vacant positions are prioritized and filled in accordance with available resources. Additional key duties are assigned to to existing staff to preserve financial resources and redirect savings toward core services.//2009//

/2010/ FTE positions within Health Services Central Office that support the MCH population include:
Managerial/administrative/budget: 32.15
Administrative Support: 13
Program Director/ Manager: 13.9
Nutritionists: 4
Social Workers: 2
Health Educator: 1
Nurses: 7.2
Data and Research Managers: 8
Total: 81.25
//2010//

/2007/In FY 2006 DHEC received additional appropriations to raise the salary levels of frontline nurses and nurse practitioners. This will enable us to raise the minimum hire level for nurses, making more in line with the competitive market. It will ultimately raise the average salaries of most nurses in the system, create greater equity and relieve compression between pay bands.//2007//

/2008/The Offices of Public Health Social Work and Public Health Nutrition were also included in the appropriation for the critical public health staff funding. Although DHEC had for some time realized the need to address salaries for nutritionists and social workers, funding was a problem. Finally, after years of submitted legislative requests, critical staff recruitment and retention funding was awarded to DHEC by the legislature. The funding that was appropriated specifically for nutrition and social work was not enough to address the full need but it helped make beginning steps in addressing salary inequities. It is expected that this beginning effort will improve DHEC's ability to recruit and retain these vital public health employees.//2008//

/2009/The Office of Public Health Nutrition actively supports MCH with continued building of staff capacity through personnel upgrades, enhanced reimbursement, technical assistance and training, and active recruitment. The Office sponsors an American Dietetic Association (ADA) approved internship program, training 15 new interns each year. The Office was active in securing licensure for registered dietitians in SC and instituting the new ADA Nutrition Care Process. It also supports and coordinates nutrition programs throughout DHEC and SC and shares state of the art protocols. //2009//

/2010/MCH lost additional capacity this year when a RD and hourly MSW retired and the position was not replaced due to budget shortfalls. The RD who manages the Newborn Metabolic Screening Program has taken on additional duties of special formula approvals //2010//

/2009/DHEC's Office of Public Health Social Work (OPHSW) continues to work with MCH to provide direct, community-based and population-based services. The number of social workers available at the regional level has dramatically decreased within the past 2 years, primarily due to budget cuts. This loss of capacity coupled with the lack of other community-based resources presents a huge barrier to families in need of assistance. On a positive note, SC has been able to maintain social work consultants in Central Office in School Social Work, WCS/CSHCN and BabyNet. At the federal level, since there is no longer a designated Chief Public Health Social Worker, states struggle to coordinate efforts. Coordination occurs chiefly through the Association of State and Territorial Public Health Social Workers (ASTPHSW) and the APHA social work section. OPHSW has played a pivotal role with the MCH/PHSW Training Projects at UNC-Chapel Hill and the University of Maryland. For the past 3 years, SC has had a student accepted into the Social Work Leadership Project at the University of Maryland.//2009//

/2010/ Due to the continued decrease of DHEC social workers, the OPHSW is promoting provision of population-based services for women, infants, children, and families and partnering with other agencies to meet identified community needs. //2010//

/2008/ The Office of Public Health Nursing also received additional funding for critical staff recruitment and retention. Nurses providing direct services received salary increases. Hopefully, this adjustment will help retain and recruit nurses needed in critical positions in the public health regions //2008//

/2009/The Office of Public Health Nursing actively supports the delivery of all MCH services. Nursing staff work closely with clients and communities. Best practice models have been implemented across the state to assure efficient and effective service delivery.//2009//

/2008/The Office of Public Health Education was not successful at receiving additional funding, however, their turnover rate is at an all time high and hopefully over the next year, additional

resources will be secured to increase the salaries of health educators specifically as needed for injury prevention, the leading cause of death for children.//2008//

/2009/The Office of Public Health Education still provides services as needed throughout the state.//2009//

/2007/The Office of Human Resources encouraged state agencies to put incentives in place for hard-to-fill positions such as nursing. In FY 2006 Health Services set aside monies to be used solely for incentives, full tuition reimbursement for those seeking to become a nurse or nurses seeking to advance their degrees, to establish a mechanism for providing sign-on bonuses, and to hire above the minimum in order to attract qualified candidates.

The Office of Nursing continues to increase its visibility by requiring nurse leaders to be active participants in professional organizations, advisory boards and committees, maintaining professional and contractual commitments with schools and colleges of nursing, submitting applications for DHEC nurses to receive local, state and nat

/2010/ The reduction in capacity of Public Health Nurses has negatively impacted the delivery of remaining services to the underserved population.//2010
An attachment is included in this section.

D. Other MCH Capacity

/2008/Bureau of Community Health and Chronic Disease Prevention

Office of Healthy Schools: To coordinate services to school children, the School Issues Team (SIT) was created to ensure communication/cooperation across bureaus.//2008//

/2009/Office of Healthy Schools partners with SDE to help schools/communities/policy-makers understand the link between health/academic achievement and developing school/community partnerships. DHEC and SDE promote an integrated/collaborative/coordinated approach to school health to affect changes in behavior/policy/ environment/practices. Office of Healthy Schools is an integral part of the SIT and ensures communication/
cooperation across bureaus to coordinate services to school children.//2009//

/2008/Division of Injury Prevention/Violence Prevention/Control is now Division of Injury/Violence Prevention/ Control (DIVPC)//2008//

/2007/Public Health Injury Surveillance/Prevention Program is the 7th injury prevention program initiated in 2006. Trauma Care Act introduced by DHEC in partnership with SC Hospital Association passed the House/Senate in 2004. Funding secured supports trauma centers continued specialized/high level care.

Yearly accidental injuries claim the lives of over 2000 SC citizens, mostly children/young adults. Unintentional injuries kill more SC children than any other cause of death. SC communities benefit from a voluntary trauma system of EMS providers/hospitals designated as trauma/rehab centers. This system ensures that injured residents receive timely/appropriate care. DHEC coordinates efforts such as the Child Passenger Seat Belt Program/Traumatic Brain Injury Emergency Surveillance/Linkage Program/Residential Fire Injury Prevention Program/SC Violent Death Reporting System (SCVDRS) to reduce child deaths from unintentional injuries.//2007//

/2008/SCVDRS collects data on victims of violent death. The DIVPC works with the Child Fatality Advisory Committee (CFAC) and SCVDRS to reduce child deaths from unintentional/intentional injuries. CFAC provided SIDS prevention education at the 2007 SCPHA annual meeting.

DIVPC's Residential Fire Injury Program installed 1500 fire alarms in targeted impoverished

areas focusing in Kershaw/Florence Counties. Target groups are low-income families with young children/elderly/disabled household members. A partnership with SC Fire Marshall's Office provides the Freddy the Fireless Feline Curriculum to K-5 in target counties. The DIVPC provides additional fire injury prevention education/TA to SC communities/organizations.

Division of Cancer Prevention/Control conducts the SC Comprehensive Cancer Control Program (SCCCC) through a cooperative agreement with CDC. The goal is to implement the SCCCC Plan to address prevention/ treatment strategies. It contracts with the SC Cancer Alliance (SCCA) to serve as the primary partner to implement the cancer plan. The SCCA works with other community organizations to build broad support for programs to reduce cancer burden. It staffs/coordinates the Cancer Control Advisory Committee (CCAC). The CCAC reviews the allocation of SC aid cancer funds used to support local cancer programs conducted by DHEC's public health regions/community partners/provides partial support for SCCA operation. DHEC subcontracts with the National Cancer Institute's Cancer Information Service (NCI-CIS) through Duke University to provide linkages/
partnerships to NCI-CIS resources to address SC cancer control. The NCI-CIS contract activities focus on reaching minority populations.//2008//

/2009/The Division of Cancer Prevention/Control subcontracts with the NCI-CIS through Duke University providing linkages/partnerships to address SC cancer control focusing on reaching minority populations.//2009//

/2007/Best Chance Network (BCN) outreach/recruitment efforts are focused on women who have never/rarely been screened and provided by American Cancer Society (ACS)/Palmetto Aids Life Support Services staff through DHEC contracts. The CDC funded Comprehensive Cancer Control Program moved from planning to implementation in 2005. The SCCCC Plan was completed and the SCCA took the lead in implementing selected plan objectives.//2007//

/2008/Continuing to focus its efforts on recruitment of rarely/never screened women beginning with the next grant cycle, BCN proposed outreach/recruitment, professional/public education be provided through a sole-source contract with the ACS.//2008//

/2007/The CCAC reviews the allocation of SC aid cancer funds for local cancer programs conducted by DHEC health regions/community partners and provides partial support to SCCA operations. It subcontracts with the NCI-CIS through Duke University. It provides linkages/partnerships to NCI CIS resources to address SC cancer control.

DHEC focuses on policies/patient care protocols to reduce the risk of disease/death, including current guidelines/ advances in disease treatment. In partnership with a variety of health/business/community leaders, DHEC has developed/implemented a Cardiovascular Health State Plan to reduce the CVD toll on SC residents and improves overall cardiovascular health. The plan identifies African-Americans as a priority/uses health promotion efforts targeting communities/work sites/schools/faith communities/health care systems.//2007//

/2008/The Heart Disease/Stroke Prevention Division, once known as the Division of Cardiovascular Health, partners to implement the Cardiovascular Health State Plan to reduce the CVD toll on SC. Efforts focus on policy/systems level support and utilize quality improvement/proven effective health promotion strategies targeting communities/work sites/schools/faith communities/health care systems.

Division of Diabetes Prevention/Control partners with the SC Primary Care Association to eliminate disparities in diabetic complications/deaths by working with providers to increase levels of prevention testing/clients' diabetic self-management skills. FQHCs provide direct care/education to medically underserved minority populations at diabetic risk. DPCP has provided mini-grants to coalitions for capacity building/work plan implementation to address diabetes in their communities. With the TA/trainings/skills provided by DPCP, more/more coalitions have

reached out to nontraditional partners to implement systems level changes in their communities.//2008//

/2009/DPCP established MOAs with 15 FQHCs within the Diabetes Collaborative/partners with other providers to eliminate disparities in diabetic complications/deaths. Goal is to increase preventive testing/clients' diabetic self-management skills. DPCP provides mini-grants to local coalitions to assist in capacity building/work plan implementation. Coalitions have increasingly sought nontraditional partners/implemented systems changes.//2009//

/2008/MCH is partnering with all Divisions within this Bureau. With more focus on the causes of chronic disease, especially for injury/childhood obesity, this Bureau became a regular part of the PAC 05/2006.//2008//

/2009/MCH and Chronic Disease met with ASTHO representatives to explore opportunities for collaboration. Much work was recognized and both bureaus strive to work together.//2009//

/2010/Two ongiong programs address tobacco use in MCH populations. Rage Against the Haze is youth tobacco prevention program that uses word-of-mouth marketing strategies to prevent teen tobacco use. Mothers Eliminating Secondhand Smoke encourages women to promote the adoption of tobacco and smoke-free policies in homes, vehicles, schools, recreational facilities and faith-based organizations.//2010//

/2010/In 2008, DHEC in partnership with the Robert Wood Johnson Foundation and the University of South Carolina, started a pilot program in family planning and WIC clinics in two public health regions to help clients receive the most effective treatment in quitting tobacco use. Health clinic staff are being trained on the "2 As +R" protocol, which outlines that healthcare providers ask patients about tobacco use, advise them to quit and refer them to cessation resources.//2010//

The Division of Obesity Prevention/Control

/2007/This Division increases SC capacity to address obesity by establishing statewide partnerships to develop a comprehensive strategic plan to maximize resources/coordinate efforts/evaluate efforts primarily focused on policy/environmental supports. Nutrition/Activity consultants support these activities through staffing of committees/groups/providing consultation/TA to local health departments/working with SC partners/ coordinating special programmatic efforts.//2007//

/2009/The Consultant-Office of Physical Activity is the Executive Director of the SC Governor's Council on Physical Fitness. The Council plans to support changes in Community Design and Complete Streets to increase physical activity by providing safer opportunities for active transportation.//2009//

/2008/The Divison focuses on nutrition/physical activity approaches to address obesity/obesity-related chronic diseases/works to build capacity in SC by focusing on policy/environmental support changes/disseminating information/enhancing coordination. The program facilitates a partnership, the SC Coalition for Obesity Prevention Efforts, and has developed a strategic plan "Moving SC Towards a Healthy Weight". The Division works collaboratively with partners to develop a Farmer's Market toolkit/other resources/surveys; is involved in promotion/implementation of the Safe Routes to School initiatives/is evaluating a preschool curriculum/is implementing an expanded program for the child-care centers.//2008//

/2007/The Office of Physical Activity focuses on policy/environmental changes to promote physical activity in SC. Programs include Safe Routes to School. Color Me Healthy, an early elementary/pre-school program designed to make young children aware of the importance of

physical activity/nutrition, is being promoted in SC. The Consultant serves as the Executive Director of the SC Governor's Council on Physical Fitness. Members of the Council were actively involved with promoting/educating on the Student Health and Fitness Act of 2005 which increases physical activity/requires healthier food choices in K-5.

Nutrition Consultant serves as the SC Five A Day Coordinator/participated in the MCH needs assessment process serving on the Reproductive Age Females workgroup/presented at the MCH 2005 Women's Health Summit/is a member of the MCH-led breastfeeding support workgroup.//2007//

/2008/The Nutrition/Physical Activity Consultants provide leadership/best practices/consultation/training to partners at the state/local levels. The Consultants provide TA to local health departments/work to integrate these risk factors into programmatic efforts of all chronic disease units/other programs within DHEC. Physical Activity Consultant acts as the Executive Director of the SC Governor's Council on Physical Fitness. Its primary focus is to increase physical activity by promoting policy/environmental change. Nutrition Consultant works closely with the WIC Nutrition Education Director by serving on the Nutrition Materials Review Committee and actively participates in the Office of Public Health Nutrition's central office consultant meetings.//2008//

/2009/Division of Obesity Prevention/Control focuses on capacity building through policy/environmental support changes/disseminating information/enhancing coordination. Team members are resources for best/promising practices by providing trainings/resources/information to support the goals of the SC Obesity Strategic Plan.//2009//

/2007/A DHEC focus in parnership with the SC Primary Care Association is to eliminate disparities in diabetic complications/deaths by working with providers to increase levels of prevention testing. CHCs reach out to medically underserved/minority populations at diabetic risk with education/care. There are 31 local diabetes coalitions that include community residents/health professionals/people living with diabetes across SC. DHEC supplies mini-grants to assist coalitions to develop/implement plans to address diabetic issues. Local coalition building continued this past year aided by mini-grants/educational programs like Diabetes Today and Diabetes 101. Community data is being analyzed to define SC diabetes needs. This effort is supported by funding from a NHHS Prevention Grant.//2007//

/2008/The Tobacco Prevention Division promotes smoking cessation efforts/services/programs/launching a new Quitline service in 08/2006 for SC citizens. Medicaid clients/pregnant women/uninsured get advanced services. Mothers Eliminating Secondhand Smoke targets the faith community to promote policy adoption for smoke-free faith/home environments for congregational members. The "Blazin' the Way" program promotes model policy adoption for tobacco-free environments by SC school districts with 11 voluntarily adopting this model policy. Efforts to promote smoke free healthcare facilities have yielded 31 policies adopted banning smoking campus wide.//2008//

Bureau of Disease Control, Division of HIV/STD

/2008/DHEC assisted CDC's Division of HIV perinatal prevention to coordinate random hospital chart abstractions during 2004/2005 to determine prenatal screening rates for HIV/syphilis/chlamydia/hepatitis B/group B Strep/ rubella. 10 hospitals serving counties with high HIV incidence among childbearing women were selected. Live births from 01/01-12/31/2003 were selected to sample/220 charts/hospital were reviewed. Prenatal care was received by 98.7% of the women selected for chart review. See preliminary results below:
Percent with Documented Screening for (n = 2,407)
Group B Strep 78.5%
HbsAg 95.8%
Rubella 82.0%

Syphilis 89.8%
Chlamydia 78.9%
HIV 85.5%//2008//

/2009/MCH and STD/HIV collaborated with USC School of Medicine/SC HIV/AIDS Clinical Training Center/SC Perinatal Association/MOD to sponsor 4 regional trainings for perinatal providers. Training goals included routine opt out HIV testing for all pregnant women/rapid testing routinely offered in all labor/delivery units for women with unknown/undocumented HIV status and full implementation of perinatal pervention steps for HIV infected women/their infants.//2009//

/2010/ STD/HIV is currently collaborating with the USC School of Medicine/SC HIV/AIDS Clinical Training Center to repeat a series of regional trainings to perinatal providers related to related to rapid HIV testing issues among pregnant women and infants.//2010//

/2008/Identification of women presenting to labor/delivery with undocumented HIV status have resulted in efforts to increase awareness for labor/delivery screening and plan trainings for hospital staff to develop policies/procedures for rapid testing of appropriate women. Currently 16 of 50 licensed delivery hospitals, located in highest prevalence areas in SC, have written policies regarding Rapid HIV Testing of women presenting to labor/delivery with undocumented HIV status. Efforts continue to provide activities in collaboration with MCH partners/the SC HIV/AIDS Clinical Training Center to promote routine screening/delivery of appropriate therapies/work to increase the number of delivering hospitals with written policies.//2008//

/2009/Identification of women presenting to labor/delivery with undocumented HIV status resulted in efforts to increase awareness for screening/hospital staff training to develop rapid testing policies/procedures. In 2006, 18 of 50 licensed delivery hospitals located in highest prevalence areas had Rapid HIV Testing written policies. MCH and STD/HIV will reassess all delivery hospitals's rapid testing policies by Fall 2008. A survey tool was drafted and MCH will obtain information from hospital perinatal staff.//2009//

/2010/ A 2008 survey of South Carolina labor and delivery units found 27 of the 43 units indicated conducting HIV rapid testing for women whose HIV status is undocumented.//2010/

/2008/DHEC contracts with USC to provide perinatal HIV prevention case management (CM) services. Case managers served a total of 47 women providing intensive CM to ensure successful linkage to prenatal/specialty care for pregnant women living with HIV and their exposed infants. Approximately 100 SC infants are exposed to HIV at birth. DHEC's case managers work with almost half of those women. DHEC's target goal is to confine the number of perinatally acquired infections in each birth cohort year to 2 or less. In 2005 and 2006 (preliminary data), there were 2 perinatal infections in each year. Funding reductions in 2006 ended the Division's contract with MUSC that supported a 50% FTE prevention case manager serving women in the Charleston area resulting in reduced capacity to serve this SC area with the 2nd highest number of new/living HIV cases.//2008//

/2009/DHEC contracts with USC to provide perinatal HIV prevention CM. In 2007, case managers provided intensive CM to ensure successful linkage to prenatal/specialty care for 35 HIV+ pregnant women and their exposed children in Sumter and Columbia. Approximately 100 SC infants are exposed to HIV. DHEC's goal is to confine perinatally acquired infection in each birth cohort year to 2 or less. In 2006 and 2007 (provisional data), there were 2 perinatal infections each year.//2009//

/2010/In 2008,Case managers served 32 HIV+ pregnant women and their exposed children in Sumter and Columbia. In 2007 and 2008, there were 2 and 1 perinatal infections respectively (provisional data).//2010

E. State Agency Coordination

/2007/The MCH Bureau is focused on building partnerships with both traditional and non-traditional partners. Over time, the desire is to continue to build the infrastructure so that less emphasis will be on the direct delivery of care and more emphasis on population or infrastructure activiites. This is a gradual process that will engage many partners and take many years.

As the structure of health care evolves, new opportunities allow DHEC to build and expand partnerships. This effort is highlighted throughout this report. In spite of economic challenges, DHEC continues to develop and maintain relationships with pediatricians, family practice physicians, obstetricians, specialty physicians and dentists. Links with community providers, schools and other organizations have been strengthened through collaboration. By joining forces with others, DHEC has forged initiatives to improve access to and quality of service. After a period of decline, partnerships with the state's medical and dental providers are increasing and improving the ability to serve families.

As an example, South Carolina Turning Point is a public-private group that supports community development and planning activities. Turning Point helps local initiatives assess community health through collaborations with government, business sector and the community. It is currently working in Orangeburg, Clarendon, Aiken, Georgetown, Pickens and Florence counties. Activities include conducting assessments of community health services, developing a health improvement plan and fostering leadership and partnership skills with stakeholders and partners. Plans are being made to implement this process statewide. DHEC has the lead role in facilitating this community wide systems approach to build a strong and effective local public health system.

Another partnership example is South Carolina's Partners in Transition. This is an interagency group committed to making a change in the lives of students with disabilities who are transitioning from their local schools into post-secondary education and/or the community and workplace. The group includes student members and parent partners who assist and advise the committee on setting goals and objectives that center around transition issues. Agencies currently involved with this committee are DHEC, Developmental Disabilities Council, Office of the Governor, Vocational Rehabilitation, Continuum of Care, State Department of Education, Midlands Technical College, SC Assistive Technology Project, Swansea High School, PRO-Parents, Family Connection, USC Center for Disability Resources and the SC Department of Corrections.//2007//

/2008/This past year has been very productive for partnership enhancement through work with inter-agency stakeholders and the ECCS Grant. Integrating systems of care for the early childhood period through partnerships promotes the likelihood that children will be healthy and ready to learn at school entry. See update of ECCS activities under Section III-B, Division of WCS. Also, partnerships with managed care continue to demonstrate promise as medical practices work with public health to promote excellence in practice and quality patient care management. See activities related to the ICS grant, Section III-A, and Agency Overview.//2008//

/2009/Funding for the ICS grant and ECCS 3 year planning cycle grant ends this year. MCH will maintain and improve upon working relationships enhanced by these grants with parent and advocacy groups and include families as integral participants in planning and decision making processes.

A continuation for the ECCS Planning Grant was awarded for Sept. 2007- August 08. During this year, leaders from each of the ECCS critical content groups participated in regional stakeholder meetings in Greenville, Florence, and Charleston. These meetings exposed new stakeholders to the purpose and scope of early childhood comprehensive planning. Dr. Baron Holmes, with SC Kids Count, reviewed SC data revealing characteristics and prevalence of children most at risk for school failure. Stakeholders then reviewed the draft strategies for the ECCS Implementation Plan and offered feedback. Work to refine the strategies has continued this year and the Implementation Plan is scheduled for on-time completion.

ECCS Early Care and Education partners support legislation to make 4K available statewide for children eligible for free and reduced lunch. This legislation would expand the current 4K pilot program to all school districts based upon available state funding and include public and private 4K placement options.

Interagency planning for ECCS implementation continued this year. DHEC sent a team to the Southern Collaborative on Obesity Reduction Efforts (SCORE) Leadership Summit. This team plans to embed nutrition and physical activity criteria into the child care quality reimbursement system. In March 2008, a state team attended the national ECCS Partners Meeting to learn how systems changes are structured in other states and explore how similar strategies might work in SC. New partnership opportunities include the First Steps and Duke Foundation funded implementation of the Nurse-Family Partnership home visitation program.//2009//

/2010/ECCS has completed the implementation plan and will start a new ECCS project implementation cycle in June 2009. The strategies outlined in the ECCS implementation plan were used in building the application for the SAMHSA Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) grant, which was submitted in May 2009. This grant provides 5 years of funding to implement a variety of targeted health promotion/prevention services for children 0-8 to one locality, while simultaneously working at the state level with ECCS to promote systems and finance coordination. The LAUNCH grant was designed to bring ECCS strategies to fruition in one locality and demonstrate challenges, benefits, and processes of change through targeted and coordinated planning and service implementation. Project LAUNCH grant announcements are expected in September 2009 to begin in October 2009. //2010//

/2008/The School Nurse Consultant has been instrumental in bringing together a collaborative of school health services leaders from local education agencies across SC with the goal of standardizing health care services provided for students to ensure that minimum standards are met. A listserv has been established for on-going discussions and a School Nurse Program Advisory Committee meets three times during each school year to discuss school health services policies and procedures. The importance of school health has been communicated to state level policy makers and in 2005, the Student Health & Fitness Act was enacted that included a promise to begin funding for school nurses for elementary schools beginning with the 2007-08 school year. Also within the 2005 state legislative session, a law was enacted that requires Individualized Health Care Plans (IHCP) for CSHCN. Coordinated efforts to educate school health professionals, educators and families regarding implementation of the IHCP requirement continued into 2006. Efforts forged through the partnership between DHEC and the SDE help to improve SC's infrastructure for supporting the health care needs of school-aged children so that they can remain in the classroom ready to learn. //2008//

/2009/ The School Nurse(SN) Consultant serves as a liaison between DHEC and the SDE to facilitate collaboration among school health services leaders from local education agencies across SC to standardize health care services for students. These partnerships improve SC's infrastructure to support the health care needs of school-aged children so that they can remain in the classroom ready to learn. A listserv allows for discussions and a SN Program Advisory Committee meets several times each school year to discuss school health services policies and procedures. State funding was designated for elementary SNs in the 2007-08 school year. Efforts continue to provide guidance to health care practitioners and school nurses to assure that students with special health care needs have IHCPs. Partnerships provide SNs and administrators clear guidance about safe practices for student care.

Cathy Young-Jones, SN Consultant, was named the 2008 Outstanding State School Nurse Consultant by the National Association of State School Nurse Consultants. Since 2002, Ms. Young-Jones has served as the School Nurse Consultant for both DHEC and SDE. According to Ann Lee, DHEC's Director of Public Health Nursing, this national award recognizes "the state consultant who displays excellence in practice by serving as a state level resource expert and

catalyst for development and implementation of policies and school health programs. Ms. Young-Jones has worked with key stakeholders to develop policies that accomodate the needs of students with chronic health conditions so that these students are afforded a safe and supportive learning environment." //2009//

/2010/The School Nurse Consultant continues to maintain relationships with nurses practicing in South Carolina's school settings and other partners with vested interests in the health of school-aged children. Through listserv communications, professional development offering and guidance developed in collaboration with the School Nurse Program Advisory Committee, efforts are being made to standardize health services for students. Relationships with health care providers have been nurtured to support the development of individual health care plans for students with chronic health conditions that are consistent with provider medical management plans. The School Nurse Consultant was instrumental in working with the SC Board of Nursing to assure advisory opinions that supported the role of the School Nurse.//2010//

/2008/The School Social Work Consultant works in an environment of collaboration between DHEC and SDE to bring opportunities to local school districts for growth in school social work services. DHEC received $250,000 from SDE to position public health social workers within six school districts specifically to address the unmet health/psychosocial needs of students who are identified as truant or chronically truant. In addition to addressing individual student and family needs, this partnership, has identified systemic issues that when resolved can contribute to increased student health and attendance, and in turn, more successful school outcomes. Time and effort spent building a public health infrastructure within the schools can contribute to sustainability of healthy environments within local school districts and communities. The School Social Work Consultant represents government (health/education) as a participant in a national project to increase the quality of services within the medical home for children on the autism spectrum through collaboration with parents, providers, HRSA/MCH, and AAP.//2008//

/2008/ The Oral Health Advisory Council and Coalition have historically made demonstrable contributions to the DOH. Recently, there have been communication and coordination challenges among the three entities. Focus groups were held with the two groups to clarify roles and expectation for each group. The process resulted in a new structure for the two groups that began officially in December 2006. In addition, the DOH has formal agreements with the Budget and Control Board's ORS, USC Arnold School of Public Health, Voices for South Carolina's Children, and EdVenture Children's Museum. Another key public-private partnership is the one between the DOH and seven School Dental Programs that provide dental services in the schools under the public health section of the Dental Practice Act. //2008//

/2007/The Division of Oral Health provides two great examples of partnerships. The South Carolina Oral Health Coalition, formed in 2003, consists of 80 members and includes partnerships from a broad stakeholder group whose purpose is to develop oral health promotion and disease prevention activities at the state and community level. The South Carolina Oral Health Advisory Committee consists of 20 members who developed the State Oral Health Plan that has identified five priorities: policy and advocacy, prevention and education, dental public health infrastructure development, dental workforce development, and access to oral health services.//2007//

/2009/The DHEC School-Based Sealant Program is a strong public-private partnership. In 2003, a section was added to the Dental Practice Act to designate DHEC as the manager of the School-based Sealant Program operating under the public health section of the Dental Practice Act. This resulted in hygienists being able to perform dental sealants in public health settings without a dental exam. Under this legislation, School-based Sealant Programs are required to complete a Memorandum of Agreement (MOA) with DHEC. For school year 2007-2008, there are 7 programs with a MOA with DHEC and about 25,000 children receive preventive services through the program yearly. The DOH has sustained a strong collaborative relationship with SC Head

Start(SCHS) since its inception. Mary Lynne Diggs, SCHS Collaboration Office Director, is a committed member of the Advisory Council. "Train the Trainer" sessions for SCHS' Regional Health Coordinators have resulted in increased capacity to plan and implement oral health activities in SCHS. DOH and SCHS presented on their partnership at the Region IV Head Start Conference. SDE and DOH have a strong collaboration existing since CDC funded an SDE children's oral health grant. This grant resulted in the development of standards-based oral health curricula and the Children's Oral Health Coalition. When the grant ended, SDE gave DHEC permission to print and distribute the curricula. This has resulted in over 500 curricula being distributed by DHEC through the School-based Sealant Program, EdVenture's Teachers Summer Institute, the Oral Health Needs Assessment (OHNA) 2007-2008 to sampled schools, and the New School Nurse Trainings.//2009//

/2007/Newborn hearing screening: First Sound, the state Early Hearing Detection and Intervention (EDHI) universal newborn hearing screening program is also housed in the Division CSHCN. State law required newborn hearing screening for all infants born in hospitals with 100 or more annual births. First Sound program works with these hospitals to assure compliance with the law and accurate reporting. State funds are used to defray hospital costs associated with these screenings, and to reimburse audiologists who provide follow up services for children with no other source of payment. HRSA/MCHB and CDC grants support First Sound follow up services and data systems.//2007//

/2008/The Newborn Hearing Screening program, First Sound, is now housed in the Newborn Surveillance Unit in WCS. In an effort to better coordinate newborn surveillance systems, this move puts First Sound in the same division as metabolic screening.//2008//

/2007/Congenital hearing loss, if undetected at birth, can cost the education system approximately $420,000 per child in special education services over the 12 years of their education. First Sound, South Carolina's Universal Newborn Hearing Screening Program, is charged with screening infants by 1 month of age, have a confirmed diagnosis by 3 months of age and receive early intervention by 6 months of age if hearing loss is identified.//2007//

/2007/As of 2004, hospitals were screening approximately 98% of babies before discharge. 270 babies were identified with some type of hearing loss. The challenge is the lost-to-follow-up rate, which is around 30% and attributed to a shortage of providers, lack of transportation, low reimbursement rates and missing demographic data. First Sound is working to improve this rate by tracking birth certificate information, developing parent-to-parent support groups and trying to improve reimbursement.//2007//

/2008/ All birthing hospitals are providing newborn hearing screening services regardless of the number of births.//2008//

/2008/The latest data from 2006 identifies 386 babies with some type of hearing loss. Preliminary data for 2006 shows an improvement in lost to follow up from a range of 30%-40% to approximately 13.5%. This improvement is primarily attributed to the hiring of a full-time employee to follow up on referrals, particularly those who do not keep the initial appointment. The program also used grant funds to purchase five pieces of equipment that provides comprehensive, diagnostic assessment and strategically placed them in facilities throughout the state to increase access to care and thus eliminate some of the need for further referral to different providers. Data is provisional because the program was without a data manager until April 2006. Now that position has been filled, final data will be forthcoming.//2008//

/2009/2007 data identifies 501 babies with some type of hearing loss. Lost to follow up has improved from 43.1% in 2005 to 19.6% in 2006. This improvement is primarily attributed to the hiring of a full-time employee to follow up on referrals, particularly those who do not keep the initial appointment. The program also used grant funds to purchase three additional pieces of equipment that provide comprehensive, diagnostic assessment. The equipment was strategically

placed in facilities throughout the state to increase access to care and thus eliminate some of the need for further referral. Although complete data is not available now, increased movement of Medicaid to managed care and continued inadequate Medicaid reimbursement levels for audiology may challenge maintenance of last year's progress made towards reducing lost to follow up.//2009//

/2010/ First Sound has been in a transitional period for data reporting. Hospitals are still working on adapting to new reporting procedures and the Program is currently working on enhancements to the reporting mechanism to further ease the transition. Partial data shows 90% screening rate and 565 total cumulative confirmed hearing losses since the Program's inception in 2001. Tremendous progress was made with Medicaid reimbursement levels for audiology however increased use of managed care through Medicaid poses new challenges to efforts to overcome those lost to follow up. Many hospitals had aging screening equipment and the program used grant funds to purchase 18 screeners for use by the hospitals in need. //2010//

/2007/DHEC has assisted the Medicaid State Plan in more than just recruiting providers to serve Medicaid recipients, but also to maintain the relationship. This is due to the very rapid expansion of MHNs.//2007//

/2008/DHEC continues to develop and maintain partnerships with providers and communicates with providers on a regular basis about Medicaid changes. See chart, "List of Managed Care Organizations by County in South Carolina" on page 2 of the Overview Section Attachment.//2008//

/2008/Although FSS has decreased in the past couple of years, the services are still offered to all populations for all programs. DHEC continues to work with providers to develop a sound referral system for FSS and other services.//2008//

/2007/Several different managed care models have been piloted or implemented via contract since the last report. In one instance, the Medicaid agency started in the fall of 2004 a new children's product entitled ‘Primary Care Case Management (PCCM) in Pickens, Oconee, and Anderson counties. The health departments in these counties and the central office are working within and with Upstate Carolina Best Care (UCBC) pilot to continue to develop and maintain the public health role in this product. Currently, the counties are in the second year of a contract to provide supportive services to clients served through this MHN.//2007//

/2008/DHEC continues to work with USC and all managed care entities to ensure that public health remains a partner in the provision of supportive and other services.//2008//

/2008/Three MCH staff members have participated extensively with DHEC Environmental Health and Environmental Quality Control, DAODAS, DSS, federal, state and local law enforcement agencies, SCDMH, and other stakeholders on the SC Methamphetamine Action Group. This multi-agency collaborative provides evidence-based information to public health/substance abuse/law enforcement/school groups via a statewide conference. The group has now broadened its perspective to include the most pressing substance abuse problem facing SC citizens each year. A primary focus of this group is the impact of methamphetamine upon the physical and psychosocial health of children and families. This group has co-sponsored the SC Community Methamphetamine Summit for the past three years, and MCH staff served as planners and facilitators during those meetings. MCH staff also helped secure a mini-grant for public awareness of the health risks associated with methamphetamine use through a collaborative effort with East Tennessee State University.//2008//

/2008/ The WCS Medical Consultant and several MCH staff members are working on a contract to provide targeted health education services to residents of SC Department of Juvenile Justice(DJJ) facilities. Other DHEC areas involved are the Office of Public Health Education,

Bureau of Environmental Health, and the Office of Public Health Preparedness.//2008//

/2009/Although DJJ and DHEC have finalized the contract for targeted health education services, hiring is on hold due to a projected DJJ budget cut.//2009//

/2008/The WCS Team Leader for program activities related to Medicaid Managed Care provides leadership to the primary care case management initiatives including training for staff in partnerships, linking to the DHEC Office of Minority Health and outside resources to promote cultural competence and organizational self assessment/change, working with the Administrative Services organizations, and interfacing with all medical home initiatives.//2008//

/2008/The MCH Adolescent Health Coordinator, two employees of the DHEC Division of HIV and STD, and two SDE representatives were chosen to attend the National Stakeholders Meeting, the purpose of which is to "Strengthen State Health and State Education Agency Partnerships to Improve HIV, STD, and Unintended Teen Pregnancy Prevention in Schools." This training and ongoing technical assistance throughout the year is funded jointly by AMCHP, Society of State Directors of Health, Physical Education and Recreation (SSDHPER), National Alliance of State and Territorial AIDS Directors (NASTAD), and the National Coalition of STD Directors (NCSD).//2008//

/2009/SC's National Stakeholders Meeting (NSM) Team applied for and received mini-grants from the national partners to fund meeting expenses for a state-level summit in August 2008 to highlight concerns regarding the high rates of STIs among SC adolescents. A SC team comprised of the State Adolescent Health Coordinator, Region 7 Family Planning Program Manager and a program coordinator from Communities in Schools of Charleston were chosen to participate in NACCHO/AMCHP's "Moving from Interest to Action" initiative. The team will travel to Chicago in July 2008 to receive training and technical assistance and will receive a $3500 stipend to assist in implementation of their project.//2009//

/2010/ SC's NSM team worked with other stakeholders to form the South Carolina State Alliance for Adolescent Sexual Health (SAASH). A SAASH summit led by an external facilitator was held on August 26, 2008. Ad hoc work groups were formed to create a program inventory, develop a system to better integrate data, and develop a position paper on adolescent sexual health. The work of these groups is ongoing. The "Moving from Interest to Action" team, with much assistance and support from others, was able to secure funding to open a teen clinic that is now operational and serves young people on John's and Wadmalaw Islands in Charleston County.//2010//

/2008/MCH staff are active participants in a wide range of state and local level collaborations, including:
1. Shared Agenda Committee: An inclusive group of state agencies (DMH, DHEC, DJJ, SDE), parents, nonprofits, and other stakeholders that work to ensure students are successful academically, socially, emotionally, and behaviorally. The group's key mission is to encourage partnering among schools, families, and agencies and look for ways to support a stronger family voice.
2. SC Youth Violence Prevention Coalition. This group, funded by a SAMHSA grant to DMH, is comprised of representatives of grass-roots organizations, the faith community, state youth-serving agencies, and law enforcement personnel throughout the state who are concerned about all aspects of youth violence, including physical and sexual assaults, gang activity, and bullying. During the past year, the coalition has sponsored and presented numerous trainings, developed and implemented an RFP process for mini-grants, and funded summer activities for at-risk youth.
3. Independent Living Advisory Committee: Interagency, statewide committee that works to ensure adolescents in foster care have the needed skills, information, and resources to transition to independent adult living.
4. Postpartum Depression Workgroup: This group includes women who have undergone treatment for postpartum depression, social workers, counselors, psychiatrists, staff of agencies

serving pregnant women and children, and mental health support groups. Participants meet monthly to develop and implement strategies to raise public awareness of the issue and locate treatment resources.

/2010/ The SC Youth Violence Prevention Coalition has disbanded but MCH staff continue to participate in the Shared Agenda, Independent Living, and Postpartum Depression groups as well as the SC Suicide Prevention Coalition, and March of Dimes African American Infant Mortality Reduction Committee. Also, 2 MCH staff members serve on the advisory council for Perinatal Awareness for Successful Outcomes (PASOS) whose mission is "to empower Latino families to optimize maternal and child health within their social and cultural context through education, outreach, partnership, and advocacy. PASOS, which is well-known in the local Latino community in areas where it exists, is considered a trusted source for information on reproductive health and for referrals to health resources and as such, has the potential for key positive impacts upon systems of care. //2010//

The MCH School Social Work Consultant:
1. Collaborates with School Social Work Association to establish their website.
2. Serves through appointment by DHEC Commissioner Earl Hunter as the agency's representative to the State Board of SC First Steps to School Readiness.
3. Serves at request of Dr. Dennis Poole, Dean, USC College of Social Work on the Student Field Advisory Committee.
4. Serves at request of State Superintendent of Education on the SC Truancy Advisory Committee to review issues, laws, and policy impacting school attendance in SC.
5. Serves on and is a charter member of Community Roundtable of School District 5 of Lexington/Richland Counties. This school/community group was organized to identify and address youth risk behaviors. The group has become model for other school districts that have initiated similar efforts and recently won national recognition for its Alcohol Enforcement Team which will now expand the concept to curb underage drinking
6. Works with SC DSS/USC College of Social Work Center for Child and Family Studies on a project to bring statewide train-the-trainers from Annie E. Casey Foundation to school social workers, guidance and other student support staff. This training is intended to increase practice skills in serving foster children within the school system in an effort to improve success for this population.

The MCH ECCS Grant Coordinator serves as DHEC's representative on the State Child Care Coordinating Council, the SC Family Literacy Advisory Council, and the Good Start Grow Smart Task Force.//2008//

/2007/Through the Medicaid Mega Services contract, paraprofessionals and professional staff recruit potentially eligible individuals into the Medicaid program. Out stationed workers assist with the eligibility process for reproductive aged women.//2007//

/2009/The focus of the Medicaid "MEGA" Services contract has changed significantly One previous focus of the MEGA contract was to increase the enrollment of primary care providers and dentists for Medicaid eligible recipients. With the expansion of managed care, the focus has changed to "establish and/or strengthen partnershps with medical/dental homes and assess and address barriers to care." Managed care entities now recruit/maintain Medicaid providers. Previously the MEGA contract included outreach activities for all children and pregnant women. Currently, it focuses on CSHCN and adolscents who are trying a new method of contraception.//2009//

/2010/ Medicaid has requested additional specific information related to Family Planning outreach for the Medicaid "MEGA" Services contract. Staff continue to focus on eligibility and utilization for CSHCN. Medicaid has indicated the focus for next year will include

pregnant women. possibly due to the barriers that pregnant Medicaid beneficiaries have faced due to the Medicaid Managed Care Auto Enrollment rollout process. Medicaid has also requested changes in deliverables related to perinatal systems.//2010//

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	52.2	40.6	38.9	36.9	30.6
Numerator	1464	1137	1109	1047	941
Denominator	280272	280272	285202	283488	307354
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

/2008/The downward trend that began in 2004 for rate of children hospitalized for asthma continued in 2006. The rate has fallen from 72.3% in 2003 to 38.9% in 2006. Interventions that address keeping young children with asthma out of the hospital continue to be successful. //2008//

/2009/The rate of children hospitalized for asthma continues to decrease although less dramatically than in previous years. The rate has fallen from 72.3 in 2003 to 36.9 in 2007. Work on interventions aimed at keeping young children with asthmas out of the hospital continues to be important.//2009//

/2010/ Rates for children hospitalized for asthma continues to decrease slowly. Interventions, such as appropriate medication use, limiting environmental triggers, and early management of asthma attacks, continue to decrease the need for hospitalization.//2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	78.2	77.6	80.4	83.5	0.0
Numerator	27453	28354	30751	34235	0
Denominator	35112	36532	38228	40981	1
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
/2008/ The percent of Medicaid enrollees less than 1 year old who received at least one initial periodic screening improved slightly in 2006 to 80.4% from 78.2% in 2004. //2008//

/2009/The percent of Medicaid enrollees less than 1 year old who received at least one initial periodic screening increased slightly to 83.5% in 2007 from 80.4% in 2006.//2009//

/2010/ A gradual increase in the percentage of Medicaid enrollees less than 1 year old who received at least one periodic screening continues to rise from 80.4% in 2006 to 83.5% in 2007. As this population is enrolled in MCOs and medical homes, this percentage should continue to increase.//2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	100.0	100.0	100.0	100.0	0.0
Numerator	1	1	1	1	0
Denominator	1	1	1	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Children <1 not eligible for SCHIP

Notes - 2006
There is not available data for 2001, 2002, 2003, 2004, because SCHIP enrollees are 1-18 years old.

Narrative:
/2008/ Children less than 1 year old are not eligible for SCHIP in South Carolina. Medicaid serves infants birth to age 1 at 185% of poverty. //2008//

/2009/Children less than 1 year old are not eligible for SCHIP in SC; Medicaid serves infants to 185% of poverty.//2009//

/2010/ Uninsured infants, under one year of age, with income above 185% but less than or equal to 200% of the Federal Poverty Level are eligible for SCHIP in SC through the

Healthy Connections Kids Program. Expansion of SCHIP benefits to this population was included in the appropriations bill in late 2007 and the program was initiated in mid-2008. Data are not yet available.//2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	84.3	85.3	84.6	85.9	0.0
Numerator	47493	49087	52629	53558	0
Denominator	56356	57538	62187	62316	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
2007 birth file not available

Notes - 2006
Data from the birth file/vital records/ PHSIS are not available for 2006 at this time because the file has not been closed. We anticipate having the data by August 2007.

Narrative:
/2008/ Data is unavailable pending the finalizing of the 2006 birth file. Residence data. //2008//

/2009/ Hispanic women often have difficulty receiving prenatal care due to lack of a payment source. SC's Medicaid clients also struggle to get early prenatal care.//2009//

/2010/ The percentage has remained consistent over the past four years. Will continue to monitor this indicator to determine the potential impact of Medicaid Managed Care auto enrollment on access to adequate and adequate plus prenatal care.//2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	88.9	89.1	89.1	85.6	86.4
Numerator	437603	438363	438526	421130	417235
Denominator	492192	492192	492000	492000	483127
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006
Numerator comes from ORS; denominator is estimate from census data. ORS number is for children aged 0-21.

Narrative:
/2008/ 2006 data is not available. //2008//

/2009/See Agency Capacity, Division of Women and Children's Services, for a discussion of children seen through EPSDT.//2009//

/2010/ 2007 data indicate a decrease in the percentage of potentially Medicaid-eligible children who have received a service paid for by the Medicaid program, returning to the 85% level of 2003 after a period of 3 years in which approximately 89% of that population received a service. The expansion of SCHIP up to 200% of the poverty level, starting mid-2008 is expected to improve the percentage of paid services when 2009 data becomes available.//2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	56.4	60.1	61.7	62.3	65.0
Numerator	59183	60937	62879	62878	65236
Denominator	104881	101331	101877	100885	100319
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
/2008/ South Carolina continued improvement for this population is due to a Dental Medicaid program with adequate reimbursement for the dental services which has been maintained approximately 50% dentist participation. In addition, the DHEC School Dental Prevention Program continues to expand its public-private partnership in schools each year. //2008//

/2009/ In the 2006-2007 school year, the DHEC School-based Sealant Program served 63% of the state's 46 counties and 52% or 44 of the state's 85 school districts. Approximately 25,000 children received preventive dental services that included dental sealants through DHEC's School Dental Programs.//2009//

/2010/One of the most compelling stories from the Oral Health Needs Assessment 2007-2008 is that children enrolled in Medicaid were experiencing higher rates of dental caries, but were most connected to care, as demonstrated by greater sealant use and lower untreated caries and treatment.//2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	18.4	18.0	46.6	23.1	0.0
Numerator	3250	1253	7380	4337	0
Denominator	17689	6959	15828	18760	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.				Yes	
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
Denominator comes from SSA Supplemental Security Record for children under 18 with SSI in SC. CDC Wonder website was used to estimate the population in SC under 18 and under 16. The percentage of under 18/ under 16 was applied to the "SSI under 18" to get the final denominator. Numerator is from semi-annual report #T0701FT to get total number of Medicaid under 16. Data was used from Region 3 databases which kept good records of this information and found that 34.4% of their Medicaid recipients under 16 had SSI. We applied that 34.4% to the entire CSHCN population under 16 with Medicaid (4,337) to get the final numerator.

Notes - 2006
Denominator comes from SSA Supplemental Security Record -- Table 7 (number and percentage distribution of children in SC receiving federally administered SSI payments) for December 2006. Numerator is from semi-annual report #T0701FT.

Narrative:
/2008/ The overview of the CSHCN assessment, plan and recommendations is detailed in the narrative III. B Agency Capacity. //2008//

/2009/See Other Program Activities for the Division of CSHCN involvement with SSI beneficiaries less than 16.//2009//

/2010/ As of December 2008, 16, 679 children under age 16 in SC received federally administered SSI payments (Source: Social Security Administration, Supplemental Security Record) In CY 2008, 24% (4,038 of 16,679) of the SSI recipients less than age 16 in SC received a DHEC service. Of the total SSI recipients in SC, 42% (8,224 of 19,630) received a DHEC service in CY 2008. Of the 8,224 SSI recipients receiving a DHEC service in CY 2008, 49% (4,038 of 8,224) were less than 16 yrs old. (Source: CARES Medicaid Type for CY 2008) //2010//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

MCH populations in the State					
Percent of low birth weight (< 2,500 grams)	2006	matching data files	11.7	8.3	10.1

Narrative:
/2008/ Update pending. Missing non-Medicaid data. //2008//

/2009/ Prematurity remains a problem in SC. Emphasis is being placed on preconception health by educating women how important their own health is for the health of their infant.//2009//

/2010/Outcomes related to short gestation, which includes low birth weight, was the second leading cause of death in 2006. More preconception health education is being developed. Additionally, partnership with the March of Dimes has created opportunities to host awareness events and forums related to prematurity issues.//2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2005	matching data files	7.9	11.6	9.5

Narrative:
/2008/ Update pending. Missing non-Medicaid data. //2008//

/2009/ Medicaid is a sign of economic status and poverty plays a role in birth outcomes.//2009//

/2010/Medicaid enrollees continue to be at higher risk for poor birth outcomes due to socio-economic status. Additionally, with changes in the structure of Medicaid, access to care may present additional concerns for this population.//2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	59.3	76.9	67.2

Narrative:

/2008/ Pending update. Provisional data indicates a decrease in the number of Medicaid women who received prenatal care in the first trimester. //2008//

/2009/ Medicaid clients still have difficulty accessing prenatal services in a timely fashion. The Medicaid Managed Companies are making this problem more difficulty as women are being auto-enrolled into plans their provider does not take.//2009//

/2010/Medicaid clients continue to have difficulty accessing prenatal care services. However, as providers work more closely with the MCO's, the process of enrolling into a selected plan is expected to improve. Additionally, some MCO's have started offering incentives to pregnant women that attend their routine prenatal visits.//2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	matching data files	56.5	85.2	84.6

Narrative:
/2008/ Pending update. Provisional data indicates that the percent of women on Medicaid with adequate prenatal care has remained fairly consistent since 2004. //2008//

/2009/ Transportation has become a greater problem for Medicaid clients with the rising cost of gasoline.//2009//

/2010/As the economy continues to struggle, and as SC maintains one of the highest unemployment rates in the country, adequate prenatal care may no longer be a priority for some pregnant women. However, referral and some outreach efforts in addition to educational materials continue to be used to emphasize the importance of adequate prenatal care.//2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**

women.		
Infants (0 to 1)	2008	185

Narrative:
/2008/ Data for infants is not available. The number 111 is used just to be able to save the form. //2008//

/2009/Infants 0 to 1 percent of poverty level is 185%. Infants less than 1 are not eligible for SCHIP.//2009//

/2010/ No change for infants 0 to 1 percent of poverty level of eligibility.//2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	200

Narrative:
/2008/ The SC Legislature approved a bill to increase Partners for Healthy Children, SC's State Children's Health Insurance Program (SCHIP) to 200% of the Federal Poverty Level (FPL). //2008//

/2009/The Partners for Healthy Children, SC State Children's Health Insurance Program (SCHIP) now covers children up to 200% of the Federal Poverty Level (FPL) poverty. SCHIP expansion began taking applications in April 2008 and enrollment began in May 2008.//2009//

/2010/ The SCHIP stand alone program covers children from over 185% of poverty up to 200% of poverty. There were 13,559 enrollees in May, 2009. This number is much lower than expected. The number of children who are eligible will probably increase due to South Carolina's climbing unemployment rate//2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	185
INDICATOR #06	**YEAR**	**PERCENT OF**

The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.		POVERTY LEVEL SCHIP
Pregnant Women	2008	185

Narrative:
/2008/ No adjustment for pregnant women. The number 111 is used just to be able to save the form. //2008//

/2009/No change for percent of poverty level for the Family Planning Waiver or regular medicaid for women.//2009//

/2010/ No change for percent of poverty level for FP Waiver or regular Medicaid for women.//2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:

/2008/ The state MCH staff have maintained strong relationships with DHEC's Office of Vital Records and
SC's Office of Research and Statistics to assist DHEC in ensuring that DHEC has access to relevant information and data. This collaboration has resulted in identifying the WIC data set as still being the most complete with other data sets (Family Planning, Child Health, Immunization) being identified as incomplete which would result in inaccurate date if linked with other data. The immunization registry has not yet been fully implemented statewide. Therefore, linking of MCH data sets across programs is not feasible at this time. The Bureau will reexamine the linking of MCH programmatic data sets after the new automated client data system the Agency is developing is fully operational. //2008//

/2008/ Several advancements in 2004 and 2005 have increased the state and Agency data collection and linkage capacities. In January 2004, the state implemented an electronic birth certificate, and in 2006 began the implementation of a new electronic lab data system. The agency is still working to ensure accuracy of data in the electronic birth certificate. Once these two electronic systems are fully operational they will enable the state to link birth certificates to newborn screening. Also, the 2004 state legislature passed legislation to develop and establish a birth defects surveillance system. Planning is underway for this new system. A coordinator has been hired and funds have been appropriated to support this new program. //2008//

/2009/ See Health Status Indicators narrative regarding MCH data collection and linkage capacities through the SSDI grant.//2009//

/2010//Advancements have been made regarding access to data. The MCH Bureau has direct access to vital records birth, death, linked birth/infant death, fetal death files. In some cases direct access to provisional data before files are formally closed is available. In addition, the Bureau has direct access to PRAMS data. This allows the Bureau to be more proactive in monitoring the health status of MCH populations in a timely fashion.//2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2010

Narrative:
/2008/ The State Department of Education conducts the YRBS every two years with the survey being conducted in 2007. MCH has access to this data, however, the 2005 data sample size was insufficient to be used for analysis. //2008//

/2009/ SC's 2007 YRBS sample size was large enough to be used for analysis. The state has made significant progress in decreasing youth tobacco use and must continue this trend through coordinated prevention and early intervention efforts at the state and local levels.//2009//

/2010/ SC DHEC's Division of Tobacco Prevention and Control in the Bureau of Community Health and Chronic Disease Prevention, in conjunction with the SC Department of Education and CDC's Office on Smoking and Health, began conducting the Youth Tobacco Survey in 2005. Three years of data are now available. //2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

/2007/The 2005-2010 Strategic Plan builds upon DHEC's mission and values, sets DHEC's direction for the next 5 years by defining goals and objectives and articulates the long-term vision for SC's future, healthy people living in healthy communities. DHEC's mission statement, we promote and protect the health of the public and the environment, reflects who we are and why we exist. Presented in our 1995 Strategic Plan, the agency's values are guiding principles that describe how we conduct ourselves in carrying out the mission. The plan provides a single strategic direction that will promote coordination and communication among the agency's programs and services and serves as a statement to the families we serve and other stakeholders.//2007//

/2008/DHEC is in Year 3 of implementation of its 2005-2010 Strategic Plan. A measurement plan for each objective has been developed and results tracked through the Strategic Plan Council. Each Deputy Area is presenting results and accomplishments pertinent to its area to DHEC's Executive Management Team. Resultswill be presented at least 5 times during the year. Those pertaining to MCH issues include pediatric immunization, family planning, unintentional and intentional injury, newborn home visits, and partnership development.//2008//

/2009/MCH measures in the 2005-2010 Strategic Plan are infant mortality, family planning, immunizations, and health disparities. The next Strategic Plan will focus on performance measure development that links to health status outcomes.//2009//

/2010/ Work has begun on the 2010-2015 agency Strategic Plan. MCH will continue as a focal point of the new planning process. The plan will be more measurable, with specification sheets required.//2010//

/2007/DHEC's goals reflect our role in carrying out the three core functions of public health: assessment, policy development and assurance. The 5-year objectives are based on determinants of health, access to care, individual healthy behaviors and good environmental quality. Many DHEC objectives are benchmarked to national standards, as the Healthy People 2010 Objectives and based on the latest health related research and scientific evidence.//2007//

/2008/In addition to using national benchmarks, programmatic targets have or are being established for each of the measures that pertain to Health Services.//2008//

/2007/The MCH Director is leading the development of a Vision Statement that will capture the Bureau's vision. A Bureau strategic plan is also being crafted that will "nest" within the Agency strategic plan referenced above. This plan will coordinate all Bureau activities into an integrated system of care. The 10 MCH priorities, as identified in last years Needs Assessment, have been incorporated into the goals and objectives outlined in the agency Strategic Plan. A measurement plan will mark progress and a scorecard will be monitored and shared. To support the implementation of the new Strategic Plan, a Performance Management System will be initiated in Summer of 2006. Modeled after the National Turning Point Performance Management Excellence Collaborative, this quality improvement process will evaluate all aspects of operations including management, human resources, data and information systems, public health capacity, financial systems, customer focus and satisfaction, and health status results. Within each of these categories, standards will be established, performance indicators developed and monitored and a quality improvement expectation placed on all managers and staff to improve operations, based on careful assessment of the data.//2007//

/2010/ In April 2009, MCH Bureau leadership engaged in a strategic planning session to clearly define our Vision and Mission and ensure programs and staffs within the Bureau are moving in the same direction.//2010//

/2008/The Performance Management System for DHEC's Health Services was piloted in the Fall 2006 and Winter 2007. From what was learned during the pilot phases, the system is being modified and updated. In July 2007, the system will be formally launched with approximately 300 performance measures being monitored that include programmatic, administrative and Professional Offices of Health Services. Performance data will be entered into a centralized system, reports generated comparing units to each other will be compiled and widely distributed, and quality improvement efforts initiated for priority performance measures. Regional MCH Block Grant plans and activities will also be monitored through this performance management data system.//2008//

/2009/The Health Services Performance Management System launched in 07/2007 has 200+ measures. 29 are MCH; others link to MCH populations such as tobacco reduction. In 10/2007, 34 priority measures were selected; 6 have MCH program responsibility. Documentation is required through QI analysis and reporting on plans implemented to improve performance from baseline. Each year measures will be evaluated/modified as needed based on new data/priorities.//2009//

/2010/The Performance Management System has finished its first complete planning, implementation and assessment cycle. Final fact sheets on each of the 34 priority measures describe progress to date.//2010//

/2007/MCH, other Health Services entities, and the Regions are all experiencing financial challenges and the public health care environment is rapidly changing. As part of managing these challenges, we have been requested to establish priorities for services, align expectations with available resources, and determine what services can be discontinued. MCH has been developing priorities and a strategic plan. Over the past few months, we have developed a concept to develop and allocate resources for priority services at the Regional level which will be implemented over the next year.//2007//

/2008/MCH continues to work with the regions to participate in DHEC's Strategic Plan. To promote optimal flexibility and accountability, MCH and the regions are identifying health outcomes that can be enhanced with a select group of potential strategies to be measured through DHEC's Performance Management System.

The CARES is being designed and implemented in phases. Deployment for Phase I was completed from 01/20/ 2004, through 08/01/2005, and included the following modules: Demographics - Client information, including name, races and ethnicities, program specific addresses and telephone numbers, family links and special accommodations information; Scheduling: Client appointments, appointment reasons, open access appointment scheduling, missed appointment, reminder letters in English and Spanish, calculated show rates, and family appointments; Records Management: Allow users to manage medical records in their sites, transfer records, archive and associate other chart numbers from private MD's to DHEC's unique Master Client Index (MCI) number; Limited English Proficiency: Reports the number of clients receiving language assistance.
Phase II and Phase III (WIC and Immunization modules) deployment was completed from 07/31/2006, through 05/21/2007. Phase IV (Family Planning, STD/HIV, Tuberculosis, and Children's Health modules) is currently under development. A work group composed of central office and regional staff will meet for the next year to provide input for module design, conduct testing and approve the module for implementation. This group will ensure that the Comprehensive Records Committee helps in making decisions related to medical records.//2008//

/2010/ Phase IV of CARES under development includes Family Planning, STD/HIV, TB and Children's Health modules. This process is expected to be completed by June 30, 2009.//2010//

/2007/The state has identifed MCH public health needs by the levels of the MCH pyramid. The role of DHEC at the community, region and state level is moving away from the provision of direct clinical services and toward building, supporting and facilitating community health care systems through public health assessment, assurance and policy development functions. While these chanes provide many rich opportunities to integrate systems and increase partnerships, it is still a paradigm shift for staff. In 2006 an effort was made to redirect resources down the MCH pyramid. MCH staff have been briefed on the pyramid and focus. The shift away from direct and enabling services should gradually continue towards population based services and building infrastructure. The greatest needs under direct health care services are related to funding for insurance coverage and increased number of h

/2009/Financial restraints have led to staff reductions resulting in a focused effort upon assurance. Medicaid Managed Care and SCHIP present opportunities for care access.//2

B. State Priorities

The 2005 needs assessment process was started in August 2004 with the establishment of a core planning group, who identified external stakeholders, created three workgroups, established methods for the workgroups to follow, and created scripts for the workgroups to ensure consistency. Recorders were selected and given uniform worksheets, so minutes would be comparable. The first step for the workgroups meetings was to generate the data books -- which, unfortunately, were late, difficult to access and understand, and difficult to relate to the final decision-making in the selection of priorities. Eventually the data books were available, and the workgroups met and reviewed to data.

One month later, the three workgroups met to discuss capacity, and the following month, data and capacity were reviewed and a combined group made up of the three workgroups selected 12 priorities. That meeting turned out to be contentious. In a follow-up planning meeting with the core planning group, a decision was made to empower the Needs Assessment coordinator and his graduate research assistant to select the priorities and complete the needs assessment. The 10 priorities were selected from the 30 priorities that the workgroups had generated in the morning of the third meeting. Information from a variety of Maternal and Child Health task forces, advisory committees, collaboratives, focus groups, Web based surveys, division meetings and activities, and general discussions was included to select the 10 priorities. Review of these inputs lead to a general understanding of capacity and informed the selection of the priorities, as much as input from the workgroups. Task forces, workgroups, collaboratives, advisory committees, etc. were made up of a wide variety of state agency partners, practitioners, DHEC district representatives, and community organizations. These partners have expressed strong interest in, at least, annual meetings to review the progress made implementing the activities generated by the needs assessment priorities and the performance measurements to judge the quality of those activities. The contributions from the qualitative process of bureau member input, based on input from our collaborators, had a greater effect on priority selection than did the quantitative data we had available.

/2007/The 2005 Needs Assessment is attached to the Block Grant application for greater detail.//2007//

During the last Block Grant application, the process used to determine the state's priorities was somewhat similar in that five population workgroups (rather than three) were formulated, who met to craft the priorities. Input from partners and collaborators were somewhat more limited in scope and in the number and variety of contributors. The needs assessment document from 2000 was far more comprehensive than this current needs assessment. It was conducted by staff members who had been in the bureau for many years and who had much more experience in this process. Data presentation and analysis was problematic during the last needs assessment process as it was this time, which emphasizes that we need to allocate resources to create and maintain MCH epidemiologic capacity, a long term serious and significant deficiency. In the five-years since the

last Block Grant application, the capacity of the Maternal and Child Health bureau has been significantly reduced, both at the central office and in the county health departments, where our services are delivered to our constituents. Budget cuts have had a dramatic impact on our capacity and ability to provide direct services, which, fortunately, does fit into our philosophical change of moving down the MCH pyramid, doing less direct service and doing more enabling, population based, and infrastructure building services, working with our partners and collaborators.

The Strengths and Needs Assessment report will be a major contributor to the development of a Epi Work Plan for the next three years, the five year Needs Assessment Work Plan, and a MCH Bureau Strategic Plan. Included in these plans will be the selection of one population (Women, Infants, Children, Adolescents, Children with Special Health Care Needs, etc) per year that has gaps in primary data collection and the selection of a method to fill these identified gaps, such as surveys of clients/care givers/providers, chart reviews, or others in order to collect missing data. The data will then be analyzed and interpreted in order to improve program planning, effectiveness, targeting, performance measures, and/or impact.

Overall, this strengths and needs assessment was very challenging for the MCH Bureau. The strengths and needs assessment will allow us to meet our mission more effectively over the next five years and will continue to influence decisions and changes within the Bureau. This assessment is not a product, but a process. We plan to re-visit our priorities regularly to reassess needs, to modify priorities, to set targets in two stages with the selection of state negotiated performance measures to monitor progress and to set national performance out come measures, to craft activities and to reallocate resources. The bureau and agency will adopt performance management systems to monitor progress, to select appropriate activities and to allocate resources in a rational fashion. From this assessment, several strengths and weaknesses emerged. The Bureau hopes to build on the current assets, create a system to support the mission and continue to outreach to the communities in South Carolina. The selection of these 10 priorities is a step along a cyclical path, with next steps of creating targeted programs for specific populations based on data from sophisticated information and analytical systems, strengthening partnerships through collaborative leadership, reallocating our resources and helping our partners adopt appropriate practices. We then will monitor progress, follow parameters through enhanced information systems, which in turn will lead to reassessment of needs and capacity, etc. continuously.

The MCH state priorities are:
1. Improve data and surveillance systems. (Infrastructure Building Service).
2. Improve access to a coordinated system of care through a systems approach. (Infrastructure Building Service).
3. Increase access to a coordinated system of care through comprehensive medical home partnerships. (Infrastructure Building Service).
4. Decrease health disparities through the utilization of cost effective strategies monitored through a performance management system. (Infrastructure Building Service).
5. Reduce unintended pregnancies. (Enabling Service).
6. Increase the application of public health research findings to public health program planning, implementation and evaluation. (Infrastructure Building Service).
7. Increase the implementation of fetal and infant death review processes. (Population Based Service).
8. Increase the initiation and duration of breastfeeding. (Enabling Service).
9. Increase access to developmental screening for children. (Population Based Service).
10. Improve access to comprehensive risk assessments. (Population Based Service).

/2007/ The wording of priority 10 has been clarified to:10. Refer and link pregnant Health Department clients to a medical home to ensure appropriate prenatal care (Enabling Service). //2007//

The Bureau has developed the following state performance measures based on these priorities.
1. Increase the percent of infant screening data systems for metabolic, hearing, birth defects, and very low birth weight linked with birth certificate data.
2. Increase the percent of newborns receiving a newborn home visit.
3. Increase the number of comprehensive medical home partnerships for pregnant women, children and CYSHCN.
4. Increase the percent of MCH programs that utilize a scorecard of measures to monitor progress.
5. Decrease the percent of family planning clients served by the health departments whose pregnancy was unintended.
6. Increase the number of MCH programs that utilized research findings to better target programs to vulnerable populations.
7. Increase the number of health departments who implemented a review process for fetal and infant deaths.
8. Increase the percent of infants who are breastfed at birth and thereafter.
9. Increase the percent of Medicaid children less than 2 years old served in comprehensive medical home partnerships that receive a developmental screening and follow up.
10. Refer and link pregnant Health Department clients to a medical home to ensure appropriate prenatal care

/2008/ Due to unforeseen barriers to measurement, huge systemic changes in the way care is delivered in the state, and marked decreases in staff available to implement the state performance measures, the following measures are inactive:
1. Increase the percent of infant screening data systems for metabolic, hearing, birth defects, and very low birth weight linked with birth certificate data.
4. Increase the percent of MCH programs that utilize a scorecard of measures to monitor progress
9. Increase the percent of Medicaid children less than 2 years old served in comprehensive medical home partnerships that receive a developmental screening and follow up. //2008//

/2009/ No changes in priorities since last year's report. Although MCH does not have the ability at this time to collect data related to all 10 priorities, activity is occurring related to each priority. //2009//

/2010/ No changes in priorities since last year's report. Although MCH does not have the ability at this time to collect data related to all 10 priorities, activity is occurring related to each priority. //2010//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	99	99	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	90	115	105	112	101
Denominator	90	115	105	112	101
Data Source					MCH
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
2007 data has been finalized

Notes - 2007
2006 data has been finalized

Notes - 2006
2005 data has been finalized.

a. Last Year's Accomplishments
/2010/No change from previous year's reporting.//2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implement the expansion of the newborn screening panel by providing consultation to hospitals, physicians and staff.			X	
2. Integrate the newborn metabolic screening data system with additional information systems such as vital records, newborn hearing and birth defects.				X
3. Prioritize the resources, needs and infrastructure of the MCH Bureau, its Divisions and its programs.				X
4. Leverage resources and build partnerships				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
2010/No change from previous year's reporting.//2010//

c. Plan for the Coming Year
/2010/No change from previous year's reporting.//2010//

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Performance Objective	85	65	75	75	80
Annual Indicator	74.1	74.1	74.1	59.4	59.4
Numerator	630	630	630	93727	93727
Denominator	850	850	850	157801	157801
Data Source					CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	85	85	85	85

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. Because SLAITS data will be used in future years (field note 2004), we have no current new estimates until this survey is repeated.

a. Last Year's Accomplishments
/2010/ Based on the 2007 National Survey of Children's Health (NSCH) data, 67.1% of SC families of CSHCN reported receiving family-centered care during the past 12 months. This is better than the nationwide rate of 65.5%. While this is a different survey than reported in Measure 2, we feel it is indicative of continuing improvement with families of CSHCN being involved in decision-making. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Train new consultants/staff, if funding permits, when hired.		X		
2. Provide information, advocacy and education to parents, families and providers.		X		
3. Develop and implement treatment plans in consultation with the families.	X			
4. Administer a patient survey tool.				X
5. Prioritize the resources, needs and infrastructure of the CSHCN Division and its programs.				X
6. Leverage resources and build partnerships				X
7.				
8.				
9.				
10.				

b. Current Activities
/2010/ Division of CSHCN continues to maintain strong ties to the state parent-to-parent organization (Family Connection). Staffing challenges continue to limit efforts to increase parent participation activities. /2010//

c. Plan for the Coming Year
/2010/ In SFY10, CSHCN Division staff will continue to work closely with Family Connection as well as other family focused service groups. The CSHCN Division will continue to work within the MCH Bureau to increase parent/family involvement in DHEC services for CSHCN. //2010//

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	95	55	95	95	95
Annual Indicator	83.5	83.5	83.5	50.6	50.6
Numerator	710	710	710	79820	79820
Denominator	850	850	850	157801	157801
Data Source					CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	95	95	95	95	95

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. There will be no change in the report for this measure until the national SLAITS data survey is repeated.

a. Last Year's Accomplishments
/2010/ Based on the 2007 National Survey of Children's Health (NSCH) data, 54.8% of SC families of CSHCN meet criteria for having a medical home. This is better than the

nationwide rate of 49.8%. While this is a different survey than reported in Measure 3, we feel it is indicative of continuing improvement in CSHCN being served by a medical home. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand the number of medical home partnerships.				X
2. Educate CSHCN parents about the importance of medical homes.		X		
3. Increase the number of CSHCN children and families served in a medical home.	X			
4. Prioritize the resources, needs and infrastructure of the CSHCN Division and its programs.				X
5. Leverage resources and build partnerships				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2010/ SFY09, CSHCN staff continued to work with medical home providers to coordinate services for CSHCN. The CSHCN nurse care coordinator funded for the primary care practice remains in place and data is being gathered to determine the effectiveness of this model within the medical home network. Division and regional CSHCN staff participated in the January 2009 CATCH conference. //2010//

c. Plan for the Coming Year

/2010/ SFY2010, CSHCN staff will continue to advocate for and promote medical homes for CSHCN. The quality of care received in a medical home will become more apparent as more data is available. The DHEC Pediatric Advisory Committee will be utilized to focus on significant issues impacting CSHCN. //2010//

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	90	60	90	90	90
Annual Indicator	91.4	91.4	91.4	60.1	60.1
Numerator	12286	12286	12286	94845	94845
Denominator	13438	13438	13438	157801	157801
Data Source					CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-					

year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. There will be no change until the SLAITS survey is repeated nationally.

a. Last Year's Accomplishments
/2010/ Based on the 2007 National Survey of Children's Health (NSCH) data, 66.2% of SC families of CSHCN reported their current insurance was not adequate. This is worse than the nationwide rate of 70.6%. While this is a different survey than reported in Measure 4, we feel it is indicative of decline in families of CSHCN having adequate insurance coverage. Results for CSHCN at the time of the 2007 NSCH indicated that 90.2% of SC respondents had health insurance at the time of the survey compared to 93.9% of respondents nationwide. This finding further demonstrates lack of adequate insurance for CSHCN in SC. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Identify, refer and assist CSHCN families who are Medicaid eligible and need insurance.		X		
2. Help secure adequate reimbursement for providers, especially pediatric sub-specialists.				X
3. Work with third party insurers to maximize benefits for CSHCN.				X
4. Prioritize the resources, needs and infrastructure of the CSHCN Division and its programs.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2010/ SFY09, CSHCN staff continued to work through the impact on services as a result of the expansion of Medicaid managed care and SCHIP in SC. DHEC staff provided feedback to DHHS on significant issues relating to the expansions of these programs. //2010//

c. Plan for the Coming Year

/2010/ SFY10, system adjustments in response to the expansion of Medicaid managed care and SCHIP will continue. //2010//

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	80	75	80	80	85
Annual Indicator	76.5	76.5	76.5	59.8	59.8
Numerator	828	828	828	94339	94339
Denominator	1082	1082	1082	157801	157801
Data Source					CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	85	85	85	85	85

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. There will be no change until the national SLAITS survey is repeated.

a. Last Year's Accomplishments
/2010/ Based on the 2007 National Survey of Children's Health (NSCH) data, 50.4% of SC families of CSHCN reported receiving effective care coordination when needed. This is better than the nationwide rate of 43.4%. The 2007 NSCH results also indicate that 24.0% of SC families of CSHCN did not need care coordination while 26.9% of families nationwide did not need care coordination. While this is a different survey than reported in Measure 5, we feel it is indicative of improvement with families of CSHCN in easily accessing service systems. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Continue tertiary and medical home partnership development				X
2. Refine case management in and through medical homes.		X		
3. Administer a client survey tool.				X
4. Prioritize the resources, needs and infrastructure of the CSHCN Division and its programs.				X
5. Leverage resources and build partnerships.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2010/ In SFY09, meetings were held with 3 of the 4 regional children's hospital's in SC to discuss effective provision of pediatric sub-specialty care. Increase service costs without an increase in funding levels resulted in a decrease in services offered through CRS. These changes were implemented in the fall and winter of 2008. //2010//

c. Plan for the Coming Year

/2010/ SFY10, meetings with regional children's hospitals will continue. Craniofacial clinic services available statewide will be reviewed and support of 4 regional craniofacial teams will be explored. Efforts to increase service coordination at the regional level for the broad population of CSHCN will be continued. //2010//

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	30	7	92	92	94
Annual Indicator	90.0	90.0	90.0	41.4	41.4
Numerator	974	974	974	22093	22093
Denominator	1082	1082	1082	53358	53358
Data Source					CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	94	96	96	96	96

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. There will be no changes until the SLAITS survey is repeated.

a. Last Year's Accomplishments
/2010/ SFY08, state level transition coordinator remains vacant. Regional CSHCN staff continued efforts to assure transition to adult care providers and ongoing health care coverage. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Retain and train transition coordinators.		X		
2. Educate parents through a strong training program.		X		
3. Expand interagency collaboration.				X
4. Administer a client survey tool.				X
5. Prioritize the resources, needs and infrastructure of the CSHCN Division and its programs.				X
6. Leverage resources and build partnerships.				X
7.				
8.				
9.				
10.				

b. Current Activities
/2010/ SFY 09, Regional CSHCN staff focused transition efforts on clients aged 17 -- 21 yrs old impacted by policy changes resulting in a decrease in available services. //2010//

c. Plan for the Coming Year
/2010/ SFY10, continued efforts to increase coordination of transition services for CSHCN across all agencies and community partners. //2010//

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	90	85	90	90	90
Annual Indicator	79.8	81.7	81.7	81.6	79.1
Numerator	89304	91431	94000	97920	96502

Denominator	111910	111910	115000	120000	122000
Data Source					Immunization
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90

Notes - 2008
2007 data has been finalized

Notes - 2007
2006 data has been finalized

Notes - 2006
2005 data has been finalized.

a. Last Year's Accomplishments
/2010/ Susan Smith, RN was appointed the Director of the Immunization Division.//2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Maintain vaccination coverage (DTaP, MMR, Polio) at 95% for children in licensed day care facilities.			X	
2. Maintain vaccination coverage levels for recommended vaccines for preschool children.			X	
3. Keep vaccine information statements (VISs) and DHEC vaccine related information up to date.			X	X
4. Reduce vaccine preventable disease and maintain an active surveillance system.				
5. Promote immunization standards within medical homes.			X	
6. Leverage resources and build partnerships.				X
7.				
8.				
9.				
10.				

b. Current Activities
/2010/ The Immunizations Division continues to work with the current SC Legislative Session to put forward a 2.4 million dollar request for additional vaccine funding for the underinsured children and adolescents in SC.//2010//

c. Plan for the Coming Year
/2010/ Efforts continue to improve our SC Immunization Information System. These efforts include greater marketing efforts in each Region, updated manuals and CDs for each of the external VAFAC providers. AARA (stimulus) vaccine money will allow the Division to

go forward with a Tdap school mandate for rising 6th graders beginning August, 2010, for the 2010-2011 School Year. The MOA with FQHCs and RHCs allowing health departments to provide vaccine to underinsured children and adolescents was accomplished and announced in March, 2009.//2010//

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	26	26	26	25	25
Annual Indicator	29.0	28.1	28.9	27.1	27.1
Numerator	2491	2469	2681	2526	2526
Denominator	86031	88020	92610	93198	93198
Data Source					Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	24	24	24	24	24

Notes - 2008
2008 birth file not available

Notes - 2007
2007 birth file is not available

Notes - 2006
This information is unavailable from PHSIS/PRAMS because they have not been able to close the 2006 birth file at this time. We hope to have the data by August 2007.

a. Last Year's Accomplishments
/2010/The continuation rate for teen less than 15 remains at 94% for FY 2008; however, the continuation rate for teens ages 15-17 decreased to 89% for this same time period. SC is also experiencing an increase in pregnancy rates for teens ages 15-17. The rate for 2006 increased from 36.5 in 2005 to 37.7 for 2006. This trend mirrors the data across the US. //2010//

/2010/ The teen clinic on John's Island has opened and is seeing an increase in the teen caseload each month. The Tobias Clinic in Spartanburg has secured funding from a private source and is continuing to serve teen clients 3 days per week.//2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote awareness through media campaigns and health			X	

care providers with the Teen Pregnancy Prevention Campaign.				
2. Collaborate with schools and community groups to provide support services in addition to clinic services.				X
3. Prioritize the resources, needs and infrastructure of the MCH Bureau and its programs.				X
4. Leverage resources and build partnerships				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2010/ DHEC will complete training and implementation of efficiency measures in all regions by late summer. To date, where these measures have been implemented, the family planning caseloads have seen an increase in clients being served. Continued budget cuts, reduction of staff and clinics have impeded increasing the caseload as was hoped.//2010//

c. Plan for the Coming Year

/2010/We continue to make teens a priority population to be served in the family planning clinics. SC DHEC now has six stand alone teen clinics and several others with special teen hours. DHEC is also partnering with several community groups to market to teens regarding services offered.//2010//

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	30	35	40	45	50
Annual Indicator	31.8	37.2	38.6	23.7	23.7
Numerator	11627	1676	7594	629	629
Denominator	36620	4506	19699	2657	2657
Data Source					MCH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50	50	50	50	50

Notes - 2008

Data are only collected every 5 years. The Division of Oral health will conduct another needs assessment in 2012.

Notes - 2007

Data provided for the years 2003, 2004, 2005, and 2006 were estimates based of the 2002 oral health needs assessment. The Division of Oral Health conducted another needs assessment in 2007. The 2007 data is lower than previous years data; however, the 2007 numbers more accurate. The formula for providing estimates in between needs assessment years will be examined for accuracy in upcoming years.

Notes - 2006
Data is obtained from school programs overseen by the Division of Oral Health. This is an underestimate of the total number of third graders with at least one sealant because school programs are not present in all school districts, nor within all schools in a given district (not all children are counted). The Division of Oral Health presumes that there is no difference between schools with or without a school program and that the percent provided by this sample is an accurate estimate for the population.

a. Last Year's Accomplishments
/2010/ There was an increase in the percentage of third grade children in SC with dental sealants from 20 percent in 2002 to 24 percent in 2008. Children enrolled in Medicaid had the highest rate of sealant use, which was significantly higher from children not enrolled in Medicaid (p>0.0001) in the OHNA 2007-2008.//2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with organized dentistry, hygienists and local schools to build partnerships that will secure oral health services.				X
2. Develop and provide data tools that will help collect and standardize this data.				X
3. Prioritize the resources, needs and infrastructure of the MCH Bureau and its programs.				X
4. Leverage resources and build partnerships				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2010/ The quality of the data collected from the DHEC School Dental Prevention Programs has improved for the current school year.//2010//

c. Plan for the Coming Year
/2010// The Division of Oral Health continues to evaluate the DHEC School Dental Prevention Program and make program improvements based on the evaluation results.//2010//

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Performance Objective	6.5	3.6	3.6	3.6	3.5
Annual Indicator	4.1	5.8	5.1	5.1	5.1
Numerator	35	49	43	43	43
Denominator	847775	847606	850790	850790	850790
Data Source					Injury Prev
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.5	3.5	3.5	3.5	3.5

Notes - 2008
This information is unavailable from PHSIS/PRAMS because they have not been able to close the 2008 death file at this time. We hope to have the data by August 2009.

Notes - 2007
Data from the birth file/vital records/ PHSIS are not available for 2007 at this time because the file has not been closed. We anticipate having the data by August 2008.

Notes - 2006
This information is unavailable from PHSIS/PRAMS because they have not been able to close the 2006 death file at this time. We hope to have the data by August 2007.

a. Last Year's Accomplishments
/2010/ During the 2007/2008 grant cycle, from October 1, 2007 -- September 30, 2008, DHEC -- Division of Injury and Violence Prevention (DIVP) established eleven safety seat fitting stations. Child Passenger Safety Instruction was provided to 222 technicians. Twenty-four 32-hour National Standardized Child Passenger Safety Training Classes were conducted. Staff also conducted (62) child safety seat inspection events and participated in outreach efforts to the Hispanic/Latino Community. In addition, they distributed 995 convertible car seats and 252 booster seats and participated in four health fairs. The DIVP provides additional child injury prevention education and technical assistance to communities and organizations across the state.

Accomplishments include: (October 1, 2008 -- March 31,2009)

5 CPS Fitting Stations established
9 CPS Classes Instructed with 83 Technicians trained
27 Safety Seat events conducted
38 CPS Presentations conducted reaching 610+ people
4 Health & Safety Fairs
310 Convertible Safety Seats distributed
47 Booster seats distributed. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Provide public education on the seatbelt and child restraint laws		X		
2. Conduct Hispanic/Latino safety seat events	X			
3. Conduct seatbelt surveys in all county health departments.				X
4. Leverage resources and build partnerships				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2010/The DIVP and child passenger safety staff continues to participate in activities performed in the previous year.//2010//

c. Plan for the Coming Year

/2010/DIVP will continue all activities as described in previous years.//2010//

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			60	61	65
Annual Indicator		56.5	38.6	37.1	37.1
Numerator		32837	21335	20600	20600
Denominator		58120	55279	55591	55591
Data Source					PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	65	65	65	65	65

Notes - 2007

Data reflects 2007 PRAMS,which ascertains breastfeeding information at 10 weeks. Previous data reflected breastfeeding at birth.

Notes - 2006

Data reflects 2006 PRAMS,which ascertains breastfeeding information at 10 weeks. Previous data reflected breastfeeding at birth.

a. Last Year's Accomplishments

/2010/All eight regions and primary care center have a breastfeeding coordinator. The percentage of women participating in WIC who breastfeed increased slightly from 26% in 2007 to 27.6% in 2008. //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand the breastfeeding peer counselor program.		X		
2. Improve the accuracy of collecting WIC breastfeeding data.				X
3. Provide training to Regional staff about data input, cultural sensitivity and the use of peer counselors.				X
4. Prioritize the resources, needs and infrastructure of the MCH Bureau and its programs.				X
5. Leverage resources and build partnerships.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2010/ State budget cuts have resulted in the reduction in the number of hours and number of breastfeeding peer counselors. All regions have breastfeeding coordinators.//2010//

c. Plan for the Coming Year

/2010/ The WIC Loving Support Breast Feeding Grant funds are used in Region 1, 3, 4, 5, and 6. Other regions have breastfeeding peer counselors funded by WIC.//2010//

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	100	100	100	100	100
Annual Indicator	98.4	99.5	98.7	97.9	90.1
Numerator	52376	53812	58221	58573	53532
Denominator	53216	54080	59000	59808	59424
Data Source					MCH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008

With the transition to the new data system, we have seen an expected, temporary, drop in hearing screeen reporting as hospitals get used to the new reporting process that requires them

to perform data entry rather than relying on batch files. Reports have been written to identify those babies whose hearing screen has not been reported, and is currently being sent to their respective hospitals.

a. Last Year's Accomplishments

/2010/ The First Sound program provided 18 hospitals with new screeners to replace aging equipment. The data integration system with Vital Records was completed. First Sound was also successful in advocating for Medicaid to increase reimbursement for certain audiology codes.//2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Visit hospitals to review First Sound reporting policies and procedures.				X
2. Present information to community and health care providers about the importance of universal newborn hearing screening			X	
3. Develop an assessment tool to monitor newborn hearing screening and evaluation outcomes.				X
4. Link data to vital records to improve the accuracy of the data collected.				X
5. Outreach to primary care providers to review and monitor compliance with protocols and procedures.				X
6. Establish a parent support network for children with hearing loss to decrease the lost-to-follow up rate.			X	
7. Prioritize the resources, needs and infrastructure of the MCH Bureau and its programs.				X
8. Leverage resources and build partnerships.				X
9.				
10.				

b. Current Activities

/2010/ The program will continue efforts to modify the hospital module of the BEE and add modules for reporting by audiologists and early interventionists to increase follow up capacity for Program Staff. In addition the program will recruit parents and professionals to spearhead establishment of a Hands & Voices chapter for SC (parent support network specific to Deaf and Hard of Hearing).//2010//

c. Plan for the Coming Year

/2010/ The program continues to work on implementing activities and strengthening data collections to reduce lost to follow up using federal grants from HRSA and CDC.//2010//

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	10	8	8	8	7
Annual Indicator	7.7	10.7	10.7	10.7	14.2
Numerator	80000	109000	110500	112000	152000
Denominator	1033000	1016000	1029000	1042000	1070000

Data Source					ORS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7	7	7	7	7

Notes - 2007
Data obtained from the U.S. Census, Current Population Survey, Annual Social and Economic Survey 2007

Notes - 2006
This information is unavailable from PHSIS at this time. We hope to have the data by August 2007.~No data was provided for 2006, numbers represent an estimate.

a. Last Year's Accomplishments
/2010/The percentage of children without health insurance is rising. Economic changes and SC's high unemployment rate have probably contributed to the rising numbers. The current Medicaid budget does not allow for expansion. Enrollment for the fully funded SCHIP stand alone program (150% to 200% of poverty) remains lower than expected. As of May there were only 13,559 enrollees. As with Medicaid, the number of eligible children will probably increase due to the economy and unemployment rate.//2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Nurture existing provider partnerships and develop new partnerships to ensure an adequate workforce to serve Medicaid and low income children in a coordinated system of care.				X
2. Educate legislators, Medicaid Agency and other advocates about expanding benefits and eligibility for Medicaid and SCHIP.				X
3. Leverage resources and build partnerships				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2010/As of January 1, 2009, DHEC began assisting with SCHIP awareness efforts. 83 packets with SCHIP information were sent out by the Care Line from January to March, 2009. SCHIP information is also available in county offices and CSHCN staff have SCHIP and Medicaid information available for families. DHEC staff also provide Medicaid enrollment broker resource information to families when needed or requested.//2010//

c. Plan for the Coming Year

/2010/DHEC continues to work and collaborate with the MCO's, Medical Home Network, and enrollment brokers. DHEC will continue to provide SCHIP and Medicaid information to families. Hard copy SCHIP applications have been requested from Medicaid and will be made available to families.//2010//

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			28	28	28
Annual Indicator		42.1	100.0	4.2	4.2
Numerator		35313	1	35313	35313
Denominator		83791	1	837910	837910
Data Source					MCH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	28	28	28	28	28

Notes - 2008
WIC data are provided by CDC with two years' time lag for data processing. We are awaiting 2006-2007 data for entry from the CDC. A placeholder will be used for 2008 data.

Notes - 2007
WIC data are provided by CDC with two years' time lag for data processing. We are awaiting 2006 data for entry from the CDC. Final data for 2007 will not be provided until 2009. A placeholder will be used for 2007 data.

Notes - 2006
WIC data are provided by CDC with two years' time lag for data processing. 2006 data will not be available until 2008. Final data for 2005 were provided to data gatherers by WIC program director but could not be entered into EHB system; HRSA tech representatives said they would enter final 2005 data for us.

a. Last Year's Accomplishments

/2010/According to CDC Pediatric Nutrition Surveillance data, Children in South Carolina continue to have lower rates of overweight and obesity. The rate for overweight in South Carolina was 15.2 % compared to the national rate of 16.4% and the rate for obesity was 13.3% compared to the national rate of 14.9 %. South Carolina has a higher rate for underweight (6.4%) compared to the National rate of 4.5%.//2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Build capacity in the state by focusing on policy and			X	

environmental support changes, disseminating best practice information and providing technical assistance.				
2. Develop a referral mechanism that targets children with a BMI at or above the 85th percentile.		X		
3. Prioritize the resources, needs and infrastructure of the MCH Bureau and its programs.				X
4. Leverage resources and build partnerships.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2010/The use (redemption rate) of the WIC Farmers Market Nutrition Program (FMNP) continues to slowly increase from 60% to 63%.//2010//

c. Plan for the Coming Year

/2010/The South Carolina WIC Program is currently implementing the new WIC food package. The new food package is implemented according to the category of participation as follows: a) May 1, 2009, all infants and breastfeeding women received the new food package, b) June 1, 2009 all postpartum and prenatal women received their new food package and c) July 1, 2009 all children will receive the new food package. There were no major problems implementing the new food package. South Carolina has trained and approved all farmers who participate in the WIC Farmers Market Nutrition Program (FMNP) to accept the WIC cash value voucher for fresh fruits and vegetables. There should be little or no impact on FMNP.//2010//

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			10	10	10
Annual Indicator		11.7	11.3	9.5	9.5
Numerator		6413	7003	5903	5903
Denominator		54663	62187	62316	62316
Data Source					Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10	10	10	10	10

Notes - 2008

2008 birth file not available

Notes - 2007
2007 birth file not available

Notes - 2006
This information is unavailable from PHSIS/PRAMS because they have not been able to close the 2006 birth file at this time. We hope to have the data by August 2007.

a. Last Year's Accomplishments
/2010/The political climate regarding smoking has changed over the past year, and more smoking bans have been implemented. These actions along with legislation to increase the cigarette tax are expected to have some impact on smoking during the last three months of pregnancy.//2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote the Smoking Cessation Quit Line to refer pregnant women to appropriate resources.			X	
2. Continue to promote smoking bans throughout South Carolina.			X	
3. Leverage resources and build partnerships.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2010/The dangers of second hand smoke to infants continue to be a statewide focus. Additionally, some regions are realizing the high percentage of women smoking during pregnancy associated with their fetal and infant mortality rates. Therefore, region-specific anti-smoking/smoking cessation campaigns for pregnant women are being developed.//2010//

c. Plan for the Coming Year
/2010/As focus shifts to preconception health programs and educational campaigns, smoking cessation for all women of reproductive age will be highlighted as a important factor for good birth outcomes.//2010//

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	6	6	6	6	6
Annual Indicator	9.5	6.7	6.3	6.3	6.3
Numerator	28	20	20	20	20

Denominator	293851	300380	315050	315050	315050
Data Source					Injury Prev
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5.5	5.5	5.5	5.5	5.5

Notes - 2007
This information is unavailable from PHSIS because they have not been able to close the 2007 death file at this time. We hope to have the data by August 2009.

Notes - 2006
This information is unavailable from PHSIS because they have not been able to close the 2006 death file at this time. We hope to have the data by August 2007.

a. Last Year's Accomplishments
/2010/ Updated data is not available for analysis at this time. MCH and Community Health and Chronic Disease Prevention Bureau staff continue to be key members of the SC Suicide Prevention Coalition. The Coalition's website is operational and its logo has been developed. SC now also has a chartered chapter of the American Foundation for Suicide Prevention (AFSP) and the Coalition will work closely with this group. The Jason Foundation continues to be key trainers for teachers, youth, and parents on the warning signs of suicide and referral resources. Mental Health America-SC is also providing some Question, Persuade, Refer (QPR) training in schools. SC data is disseminated at a state workshop each fall. AFSP held a suicide prevention event in April at the University of South Carolina (USC) in collaboration with the USC Counseling Center and students, which included a student panel and interviews on a radio station //2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue work of the statewide coalition to address suicide prevention issues.				X
2. Develop a directory of suicide survivor groups in South Carolina.			X	
3. Hold a data dissemination workshop to include data related to violent deaths.				X
4. Leverage resources and build partnerships.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2010/ The Coalition's key project for this year is to develop a brochure detailing SC's suicide prevention strategies, including a section pertaining to schools. We have received

permission from Florida to adapt the content of their existing brochure for South Carolina audiences. The SC AFSP Chapter and MHA-SC are both contributing funding for this project.//2010//

c. Plan for the Coming Year
/2010/ SC will:
1. Update the State Suicide Prevention Plan, which was developed in 2005, after the national plan is revised in 2010
2. Finalize, print, and disseminate the suicide prevention brochure
3. Participate with a group of agencies throughout the state to provide schools with a comprehensive manual including resources on a variety of programs, including suicide prevention, available for student safety. This "Student Protection Project" may also include legislation.//2010//

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	82	80	82	84	84
Annual Indicator	77.6	77.4	78.5	73.2	73.2
Numerator	874	878	864	931	931
Denominator	1126	1134	1100	1272	1272
Data Source					Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86	86	86	86	86

Notes - 2008
2008 birth file not available

Notes - 2007
2007 birth file not available

Notes - 2006
This information is unavailable from PHSIS/PRAMS because they have not been able to close the 2006 birth file at this time. We hope to have the data by August 2007.

a. Last Year's Accomplishments
/2010/ In 2007, 73.2% of all very low birth weight babies were born in a level III facility. This represents a decline from levels observed in 2006. Assuring access to care for the smallest and sickest babies has is becoming more challanging with reductions in the overall capacity and transitions to Medicaid Managed Care.//2010//

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partner with the March of Dimes on the campaign to prevent premature birth.				X
2. Continue partnership with AME Church to educate and increase awareness about infant health, including low birth weight and premature births.				X
3. County Health Departments will provide education to pregnant women about the signs and symptoms of premature labor.	X			
4. Track where VLBW infants are delivered.				X
5. Provide technical assistance to hospitals to transfer appropriate prenatals when necessary.				X
6. Prioritize the resources, needs and infrastructure of the MCH Bureau and its programs.				X
7. Leverage resources and build partnerships				X
8.				
9.				
10.				

b. Current Activities

/2010/Very Low Birth Weight deliveries continue to be tracked in order to identify any gaps in services. Additionally, a partnership with the March of Dimes prematurity campaign has been established.//2010//

c. Plan for the Coming Year

/2010/Staff will continue to work with hospitals to assure access to care for the smallest and sickest babies. Staff will monitor maternal/fetal and newborn transfers to appropriate level III facilities and continue education outreach activities on the importance of prenatal identification and transfer of high-risk mothers. //2010//

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	82	70	74	76	80
Annual Indicator	64.9	69.3	67.2	68.3	68.3
Numerator	36681	39889	41778	42990	42990
Denominator	56543	57538	62187	62933	62933
Data Source					Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**

Annual Performance Objective	90	90	90	90	90

Notes - 2008
2008 Birth File not available

Notes - 2007
2007 birth file not available

Notes - 2006
This information is unavailable from PHSIS/PRAMS because they have not been able to close the 2006 birth file at this time. We hope to have the data by August 2007.

a. Last Year's Accomplishments
/2010/The Managed Care Organization structure continues to create problems for pregnant women enrolling in prenatal care. However, many of these barriers have been addressed and progress is being made. With the economic downturn, it is expected that more women will be applying for Medicaid.//2010//

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. County Health Departments will risk assess when there is a positive pregnancy test and follow-up with any prenatal to ensure entry into care.	X			
2. Educate through the Caring for Tomorrow's Children Program.			X	
3. Prioritize the resources, needs and infrastructure of the MCH Bureau and its programs.				X
4. Leverage resources and build partnerships				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2010/Educational campaigns about the importance of prenatal care continue. Additionally, the Nurse Family Partnership program has been implemented in 6 sites (4 DHEC, 2 Hospital) across the state. This program is expected to assure that participants in the program receive early and adequate prenatal care.//2010//

c. Plan for the Coming Year
/2010/SC will continue to address barriers to accessing prenatal care, including Medicaid enrollment, cultural beliefs, and general awareness of its importance. The previously-mentioned PASOS program has the potential to positively impact the adequacy of prenatal care for Latina women. Additionally, support will be given to programs encouraging prenatal care services, such as the Nurse Family Partnership.//2010//

D. State Performance Measures

State Performance Measure 2: *Increase the percent of newborns receiving a newborn home visit.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			55	60	60
Annual Indicator	46.0	40.3	44.2	40.4	0.0
Numerator	12900	13005	14670	14380	0
Denominator	28032	32266	33219	35565	1
Data Source					ORS
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	65	65	65	65	65

Notes - 2006
Numbers used to save form only; data not yet available from ORS.

a. Last Year's Accomplishments
/2010/ The number of newborns eligible for a PPNBHV continued to increase in 2007, prior to the availability of funding for additional RNs to provide PPNBHVs, resulting in a decrease in the percent of newborns receiving the visit. In 2006, several non-DHEC providers of PPNBHVs decreased the visits made or discontinued the service altogether, further limiting state capacity to serve additional families. While funding to support additional RN FTEs was dispersed to the regions during SFY08, many areas faced challenges in filling positions. The Nurse Family Partnership Program is an opportunity for home visits, however current capacity of the program is limited. It is operational in 6 sites throughout South Carolina and, when full caseloads are built, will serve a maximum of 600 first-time low income mothers. //2010//

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Prioritization of newborn home visits will continue in 2009.				X
2. Newborn home visit clients will be referred to a medical home.				X
3. Technical assistance and consultation will take place with the regions to ensure newborn home visits remain a top priority.				X
4. Prioritize the resources, needs and infrastructure of the MCH Bureau, its Divisions and its programs.				X
5. Leverage resources and build partnerships.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2010/ DHEC continues to provide training, support, and technical assistance to regions for the PPNBHV service. A minimal number of additional RNs were hired in response to the additional state funding SFY08, in part because of limited applicant response to open positions in many areas of SC. In most regions, budget cuts during SFY09, including the loss of continued state funding for the additional RN positions, significantly limited the ability of most regions to replace RNs who retired or separated from the agency.//2010//

c. Plan for the Coming Year
/2010/ As noted in 2009, DHEC will continue to provide support to the regions to provide PPNBHVs, including training, infrastructure maintenance, technical support, and negotiations with MCOs to make PPNBHVs available to all mothers and infants.//2010//

/2010/ DHEC is providing significant administrative/programmatic support in the implementation of NFP.//2010//

State Performance Measure 3: *Increase the number of comprehensive medical home partnerships for pregnant women, children and CYSHCN.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			30	45	60
Annual Indicator					
Numerator		10	10	10	10
Denominator		10	10	10	10
Data Source					N/A
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	75	90	90	90	90

Notes - 2008
No data for this indicator

Notes - 2007
No data for this indicator

a. Last Year's Accomplishments
/2010/ DHEC continues to promote medical homes and this remains an ongoing priority. Expansion of Medicaid managed care facilitated an increase in the availability and use of medical homes. However, budget cuts have impacted DHEC's ability to either co-locate services, have DHEC staff located within medical homes to provide services, and/or devote staff time to partnership promotion. DHEC is exploring ways to continue to partner with providers to ensure that patients receive needed services. A Medical Home Team (MHT) Meeting was held on April 1, 2009. Discussion included: 1) quality improvement techniques, requirements, and learning collaborative opportunities and 2) collaboration with Help Me Grow (HMG). HMG is an initiative being implemented in Greenville to connect and refer children to services who are identified as at-risk through developmental screenings but do not meet criteria for Baby Net, the state's Part C program. Referrals will be facilitated through a toll-free line operated by certified staff. The updated SC Medicaid managed care contracts will include quality improvement standards. The MHT wanted to ensure that providers have a uniform set of quality measures to address. As a next step Dr. Rushton (MCH's Medical Consultant) was to coordinate a meeting with DHHS and managed care to discuss a standard quality improvement process. A Medicaid Managed Care Medical Advisor meeting was held on June 2, 2009 and Dr. Rushton attended that meeting. //2010//

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Work with physicians to specify what is included in collaboration and communication for a continuum of care.				X
2. Develop and implement a CQI process.				X
3. Establish partnership goals on the regional and local level.				X
4. Prioritize the resources, needs and infrastructure of the MCH Bureau, its Divisions and its programs.				X
5. Leverage resources and build partnerships.				X
6. Gather data on existing partnerships.				X
7.				
8.				
9.				
10.				

b. Current Activities

/2010/ SFY09, the partnership of USC, SC Solutions, DHEC Region 3 and the Division of CSHCN continued. The nurse care coordinator for CSHCN continued to be funded via USC and provided through DHEC Region 3. Data collection began this year on the services provided by the nurse care coordinator. Collaboration with Family Connection continued. Pediatric care providers, hospitals and insurance plans participated in the annual CATCH conference held in January 2009 along with DHEC regional and division staff. //2010//

c. Plan for the Coming Year

/2010/ SFY10, data review from services provided by the nurse care coordinator for CSHCN will begin. Collaboration with USC, SC Solutions and DHEC will continue. Collaboration with Family Connection will remain a priority. Another MHT meeting was to be scheduled based upon the outcome of the meeting with DHHS/managed care regarding quality improvement. //2010//

State Performance Measure 5: *Decrease the percent of family planning clients served by health departments whose pregnancy was unintended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			45	45	45
Annual Indicator	0.0	0.0	50.2	44.7	0.0
Numerator	0	0	28497	25070	0
Denominator	1	1	56806	56039	1
Data Source					MCH
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	45	45	45	45	45

Notes - 2007

We don't know whether an individual is a family planning client served by health departments. However, we do collect data on pregnancy intention on the general population of SC. This is the data that reflects that surveyed info.

Notes - 2006

Family planning clients are not asked about pregnancy intendedness.

a. Last Year's Accomplishments

/2010/ The percentage of pregnancies that were unintended in 2007 was at 44.7, which is significantly lower than the reported percentage of 50.2% for 2006. The 2006 rate of 50.2% was the highest percentage in the past 14 years; however, the 2007 rate of 44.7% is the second lowest. It is uncertain whether the recent percentage drop is the beginning of a downward trend or a result of statistical variation. We will continue to monitor in the context of the overarching trend. //2010//

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote and support the integration of services within health department clinics.	X			
2. Offer flexible clinic hours.	X			
3. Family planning providers will successfully complete a course on Preventive Health.				X
4. Prioritize the resources, needs and infrastructure of the MCH Bureau, its Divisions and its programs.				X
5. Leverage resources and build partnerships.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2010/ DHEC continues the priority of access to quality family planning services in all 67 clinic sites. The Preventive Health course continues to train RNs to work as an expanded role nurse. DHEC will complete training regional staff to use the Windows-based Patient Flow Analysis (PFA) system by late summer 2009. So far, 7 of the 8 regions have completed the training in the past 18 months. //2010//

c. Plan for the Coming Year

/2010/ Plans are for all regions to complete at least one PFA for each clinic site to determine how recommendations made following the initial PFAs have impacted on the clinic flow and increased caseloads. //2010//

State Performance Measure 6: *Increase the number of MCH programs that utilized research findings to better target programs to vulnerable populations.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			40	50	60
Annual Indicator		30.3	34.3	34.3	34.3
Numerator		10	12	12	12
Denominator		33	35	35	35
Data Source					N/A
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	80	80	80	80

Notes - 2008

No clear means of collecting this information. Numbers provided are an estimate.

Notes - 2007
No clear means of collecting this information. Numbers provided are an estimate.

Notes - 2006
Numerator - number of MCH programs in the state that use research to target their interventions; denominator - number of MCH programs in the state. There is currently no measurement system in place to gather information on this; estimate is based on 2005 numbers.

a. Last Year's Accomplishments
/2010/ In the past year the Bureau has completed or been involved in research projects on Preventive Dental Cleanings and Pregnancy; Racial Differences in Sleep Position, Infant Mortality Time Trend Analysis, Perinatal Periods of Risk (PPOR), Prematurity in South Carolina, PPNBHV Utilization and GIS mapping of Risk Factors Associated with VLBW Outcomes.//2010//

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Train the newly hired Assistant MCH Bureau Director and Division Director for WCS and MCH Epidemiologist.				X
2. Encourage every MCH division and program to identify and use research to target their programs.				X
3. Prioritize the resources, needs and infrastructure of the MCH Bureau, its Divisions and its programs.				X
4. Leverage resources and build partnerships				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2010/ Results from the above mentioned projects are being shared with key program staff and stakeholders. Information pertinent to a specific program will be incorporated into program planning activities. The Bureau is in the process of creating formal documents available for internal distribution and external distribution to other key stakeholders.//2010//

c. Plan for the Coming Year
/2010/ Focus has shifted to gathering data for the upcoming Needs Assessment. The process of gathering data/information from programs for the Needs Assessment illuminates needs in program areas for increased utilization of research findings. The Needs Assessment process will be used to identify program areas with opportunities for improvement.//2010//

State Performance Measure 7: *Increase the number of health departments who implemented a review process for fetal and infant deaths.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			50	55	60
Annual Indicator		45.7	23.9	19.6	34.8
Numerator		21	11	9	16
Denominator		46	46	46	46
Data Source					MCH
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	65	70	75	75	75

a. Last Year's Accomplishments

/2010/In 2008 16 counties indicated some FIMR program activities. Moving forward, attention has been given to counties and regions where FIMRs existed at one point but have since been phased out. We have been successful in reviving three FIMR teams so far. Local FIMR teams identified barriers to conducting case reviews. A plan was developed to implement a FIMR Database and a State Review Team.//2010//

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. FIMRs will continue to work on the problems of prematurity, Safe Sleeping, and will also begin to work on the importance of preconception heath.				X
2. Prioritize the resources, needs and infrastructure of the MCH Bureau, its Divisions and its programs.				X
3. Continue efforts to develop a centralized FIMR process				X
4. Leverage resources and build partnerships.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2010/Efforts to revive more local FIMR teams continue. Partnerships are also being established with Healthy Start. Specifically, Low Country Healthy Start has agreed to assist in conducting Home Interviews. Additionally, plans to implement the FIMR Database continue. The new database would remove database abstraction barriers that many of the counties and regions have encountered.//2010//

c. Plan for the Coming Year

/2010/Within the next year, it is expected that the FIMR Database will be ready for use. Efforts are targeted at completing the database, establishing the state review team, facilitating revival of local case review teams, and initiating community action teams across the state.//2010//

State Performance Measure 8: *Increase the percent of infants who are breastfed at birth and thereafter.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			48	50	53
Annual Indicator		56.5	57.3	58.2	61.3
Numerator		32519	35624	36279	36707
Denominator		57538	62187	62316	59840
Data Source					PRAMS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	55	58	60	60	60

Notes - 2008
2008 birth file is not available

Notes - 2007
2007 birth file is not available

Notes - 2006
Provisional data based on breastfeeding indicator at the time of birth

a. Last Year's Accomplishments
/2010/ See update under National Performance Measure #11//2010//

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Hospitals and the regional centers will offer educational classes on breastfeeding and the services of a lactation counselor.			X	
2. Prioritize the resources, needs and infrastructure of the MCH Bureau, its Divisions and its programs.			X	
3. Leverage resources and build partnerships.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2010/ See update under National Performance Measure #11//2010//

c. Plan for the Coming Year
/2010/ See update under National Performance Measure #11 //2010//

State Performance Measure 10: *Increase the percent of pregnant women who are health department clients who are linked and referred for prenatal care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			100	100	100

Annual Indicator		100.0	100.0	100.0	100.0
Numerator		100	100	100	100
Denominator		100	100	100	100
Data Source					MCH
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2006
All women who present as pregnant are referred for prenatal care.

a. Last Year's Accomplishments
/2010/ No change in practices associated with this indicator, all pregnant women seen in health departments are linked and referred for prenatal care.//2010//

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Educate regional staff to provide prenatal care linkage and referral for women with positive pregnancy test to decrease barriers to care and encourage early enrollment in a medical home.			X	
2. Prioritize the resources, needs and infrastructure of the MCH Bureau, its Divisions and its programs.				X
3. Leverage resources and build partnerships.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
/2010/ Auto enrollment practices of Medicaid Managed Care continue to pose challenges to women seeking prenatal care. The OB Task Force continues to work on this issue with DHHS.//2010//

c. Plan for the Coming Year
/2010/ There are no change in plans for the upcoming year. Work will continue to assure health department clients with a positive pregnancy test are linked and referred to prenatal care.//2010//

E. Health Status Indicators

Introduction
/2010/The Indicators outlined in this section are monitored to obtain a general sense of the overall health status of MCH populations of South Carolina. Data related to birthweight and mortality generally come from reliable sources are are monitored on a routine basis

by programs. Data from these indicators are used when conducting assessments and considering program outcomes. Data for the other soci-demographic indicators comes from less reliable resources and used cautiously.//2010//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	10.2	10.2	10.2	10.1	0.0
Numerator	5769	5895	6313	6317	0
Denominator	56543	57538	62187	62316	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
2007 Birth File has not been released

Notes - 2006
Data from the birth file/vital records/ PHSIS are not available for 2006 at this time because the file has not been closed. We anticipate having the data by August 2007.

Narrative:
/2010/The percent to of live births weighing less that 2,500 grams has remained stable over the past several years. Efforts continue to improve the health of the mother before and during pregnancy and assure access to early and adequate prenatal care to improve birth outcomes.//2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	8.4	8.4	8.4	8.3	0.0
Numerator	4568	4694	5027	4977	0
Denominator	54643	55703	60106	60200	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
2007 birth file is not available

Notes - 2006

Data from the birth file/vital records/ PHSIS are not available for 2006 at this time because the file has not been closed. We anticipate having the data by August 2007.

Narrative:
/2010/The number of singleton births has remained stable over the past several years. Efforts continue to improve the health status of the mother before and during pregnancy, and improve access to early and adequate prenatal care.//2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	2.1	2.1	1.9	2.0	0.0
Numerator	1193	1195	1158	1272	0
Denominator	56543	57538	62187	62316	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
2007 birth file is not available

Notes - 2006
Data from the birth file/vital records/ PHSIS are not available for 2006 at this time because the file has not been closed. We anticipate having the data by August 2007.

Narrative:
/2010/The percent of live births weighing less than 1,500 grams has remained constant over time. Program focus to improve this indicator continues to be on improving the health status of the mother before and during pregnancy. South Carolina has historically had a very strong regionalized system of perinatal care, assuring these babies have access to the highest quality care to improve survival. Program efforts on both fronts will continue.//2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.7	1.6	1.5	1.7	0.0
Numerator	935	915	916	1015	0
Denominator	54643	55703	60106	60200	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
2007 birth file is not available

Notes - 2006
Data from the birth file/vital records/ PHSIS are not available for 2006 at this time because the file has not been closed. We anticipate having the data by August 2007.

Narrative:
/2010/There was a slight increase between 2006 and 2007; however, in the context of the past 3 years the percent of live singleton births weighing less than 1,500 grams has remained constant. Efforts continue to improve the health status of the mother and assure access to quality sub-speciality care for these infants.//2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	9.5	12.9	13.3	0.0	0.0
Numerator	75	109	113	0	0
Denominator	791726	844090	850790	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data from the birth file/vital records/ PHSIS are not available for 2008 at this time because the file has not been closed. We anticipate having the data by August 2009.

Notes - 2007
Data from the birth file/vital records/ PHSIS are not available for 2007 at this time because the file has not been closed. We anticipate having the data by August 2008.

Notes - 2006
Data from the birth file/vital records/ PHSIS are not available for 2006 at this time because the file has not been closed. We anticipate having the data by August 2007.

Narrative:
/2010/The death rate for unintentional injury among children aged 14 years and younger has increased notably from 2004.//2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.3	5.8	5.1	0.0	0.0
Numerator	34	49	43	0	0
Denominator	791726	844090	850790	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data from the birth file/vital records/ PHSIS are not available for 2008at this time because the file has not been closed. We anticipate having the data by August 2009.

Notes - 2007
Data from the birth file/vital records/ PHSIS are not available for 2007 at this time because the file has not been closed. We anticipate having the data by August 2008.

Notes - 2006
Data from the birth file/vital records/ PHSIS are not available for 2006 at this time because the file has not been closed. We anticipate having the data by August 2007.

Narrative:
/2010/The death rate for unintentional injuries due to motor vehicle crashes for those under 14 decreased from 5.8 in 2005 to 5.1 in 2006. The Division of Injury and Violence Prevention continues efforts related to child passenger safety and works to ensure this rate continues to decrease.//2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	55.1	41.4	39.5	0.0	0.0
Numerator	334	252	242	0	0
Denominator	605789	609060	611950	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data from the birth file/vital records/ PHSIS are not available for 2009 at this time because the file has not been closed. We anticipate having the data by August 2009.

Notes - 2007
Data from the birth file/vital records/ PHSIS are not available for 2007 at this time because the file has not been closed. We anticipate having the data by August 2008.

Notes - 2006
Data from the birth file/vital records/ PHSIS are not available for 2006 or 2007 at this time because the files have not been closed. We anticipate having the data by August 2008.

Narrative:
/2010/The death rate for unintentional injuries due to motor vehicle crashes for those 15-24 has decreased from 55.1 in 2005 to 39.5 in 2006. The Division of Injury and Violence Prevention continues activities to ensure this rate continues to decrease.//2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	9,687.7	9,363.6	8,917.2	0.0	0.0
Numerator	76661	79037	75867	0	0
Denominator	791323	844090	850790	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
Data from the birth file/vital records/ PHSIS are not available for 2007 at this time because the file has not been closed. We anticipate having the data by August 2009.

Notes - 2006
Data from the birth file/vital records/ PHSIS are not available for 2006 at this time because the file has not been closed. We anticipate having the data by August 2008.

Narrative:
/2010/The rate of non-fatal injuries among children under 14 has dropped by 8% since 2004. Efforts within the Division of Injury and Violence Prevention will continue to work towards decreasing this rate.//2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	711.6	670.1	601.7	0.0	0.0
Numerator	5631	5656	5119	0	0
Denominator	791323	844090	850790	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
Data from the birth file/vital records/ PHSIS are not available for 2007 at this time because the file has not been closed. We anticipate having the data by August 2009.

Notes - 2006
Data from the birth file/vital records/ PHSIS are not available for 2006 at this time because the file has not been closed. We anticipate having the data by August 2008.

Narrative:
/2010/The rate for this indicator has dropped by 15% since 2004. Efforts within the Division of Injury and Violence Prevention will continue to work to decrease rates for this indicator.//2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	2,905.6	3,080.3	2,931.1	0.0	0.0
Numerator	17602	18660	17937	0	0
Denominator	605789	605789	611950	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
Data from the birth file/vital records/ PHSIS are not available for 2007 at this time because the file has not been closed. We anticipate having the data by August 2009.

Notes - 2006

Data from the birth file/vital records/ PHSIS are not available for 2006 at this time because the file has not been closed. We anticipate having the data by August 2007.

Narrative:
/2010/The rate for this indicator has been farily stable from 2004-2006. Division of Injury and Violence Prevention will continue to ulilize this indicator to monitor program activities.//2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	44.8	42.7	47.2	52.9	52.7
Numerator	6314	6116	6229	8220	8297
Denominator	140829	143376	131913	155330	157541
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Numerator Data for chlamydia were obtained from Terri Stephens, Division of Epidemiology.

Denominator data from CDC Wonder:
http://wonder.cdc.gov/population-projections.html

Notes - 2006
Data for chlamydia were obtained from Terri Stephens, Division of Epidemiology. Denominator data from 2005 US census estimate for population.

Narrative:
/2010/The 2008 rate is slightly lower than the 2007 rate. Although the rate increased steadily from 2004-2007, increases could be due to increased surveillance activities. Decreasing capacity within the agency and local health departments could potentially influence this indicator moving forward.//2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	13.0	12.4	12.9	16.3	16.0
Numerator	9665	9288	9479	11824	11610
Denominator	743286	746169	734033	723460	723460
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Data for numerator are from Terri Stephens, Division of Epidemiology.

Denominator data is from CDC Wonder:
http://wonder.cdc.gov/population-projections.html

Notes - 2006
Data for numerator are from Terri Stephens, Division of Epidemiology. Denominator data is from 2005 Census estimate for population group.

Narrative:
/2010/The 2008 rate was slightly lower than the 2007 rates. There was a marked jump from 2006 to 2007, hopefully the 2008 rate markes the beginning of a downward trend. However, reduced capacity in the agency and local health departments could influence this indicator moving forward.//2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	69218	45943	23275	0	0	0	0	0
Children 1 through 4	238136	144530	83265	0	2014	0	8327	0
Children 5 through 9	279046	171797	90546	0	7134	894	8675	0
Children 10 through 14	292075	186633	95422	0	4648	0	5372	0
Children 15 through 19	306303	181405	107906	5572	5020	0	6400	0
Children 20 through 24	291432	189813	93679	0	3169	0	4771	0
Children 0 through 24	1476210	920121	494093	5572	21985	894	33545	0

Notes - 2010

Narrative:
/2010/Changes in demographics are an important indicator to consider. As the number of births continue to increase, the numbers of individuals within each category will also gradually increase. This can have an impact on the potential need for services and service delivery within the state.//2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	68230	988	0
Children 1 through 4	225694	12442	0
Children 5 through 9	273575	5471	0
Children 10 through 14	283901	8174	0
Children 15 through 19	288499	17804	0
Children 20 through 24	283225	8207	0
Children 0 through 24	1423124	53086	0

Notes - 2010

Narrative:
/2010/Changes in State demongraphics related to Ethnicity is very important to monitor. The number of individuals in the State identified as Hispanic is steadily increasing. This increase brings about a greater demand for services often provided by health departments, which also creates challanges in providing culturally competent care. It is important to factor this demographic shift into services provided.//2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	124	47	71	2	0	0	4	0
Women 15 through 17	2526	1211	1246	4	13	0	50	2
Women 18 through 19	5749	2943	2658	17	12	2	112	5
Women 20 through 34	47341	30881	14992	180	719	27	503	39
Women 35 or older	6572	4838	1481	23	168	3	54	5
Women of all ages	62312	39920	20448	226	912	32	723	51

Notes - 2010

Narrative:
/2010/The actual number of births in the State has steadily increased over the past several years, with implications that warrant consideration. This indicator can be a starting point to determine identify missed opporunities for prevention of mistimed or unwanted pregnancies. This also represents an increase in the need to inter-conception care among women to ensure subsequent pregnancies are planned. In addtion, as the number of births

increase so does the potential for the number of infants with poor birth outcomes in need of services.//2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	109	15	0
Women 15 through 17	2228	298	0
Women 18 through 19	5231	518	0
Women 20 through 34	42441	4891	9
Women 35 or older	6072	499	1
Women of all ages	56081	6221	10

Notes - 2010

Narrative:
/2010/The number of pregnancies among women identifyed as Hispanic has many implications. The majority of emergency medicaid deliveries are among Hispanic women. In addition, these women often find it more difficult to access early and adequate prenatal care which can have an impact on birth outcomes. This indicator has implications for family planning services in that it represents an increased demand among women who can have trouble obtaining these services under federal CMS policies requiring proof of citizenship.//2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	520	230	281	2	1	0	1	5
Children 1 through 4	71	31	39	0	0	0	1	0
Children 5 through 9	43	24	19	0	0	0	0	0
Children 10 through 14	62	35	26	0	1	0	0	0
Children 15 through 19	237	146	85	0	5	0	0	1
Children 20 through 24	394	235	153	0	3	0	0	3
Children 0 through 24	1327	701	603	2	10	0	2	9

Notes - 2010

Narrative:
/2010/This indicator if of particular importance. One primary objective of improving the health and well being of MCH poulations would be to impact preventable deaths. This indicator provides insight into which agegroup provide the greatest opportunity to prevent deaths. The underlying cause of death among each of the age breakouts can be quite different. The majority of infant deaths occur during the first 28 day of life which are primarily associated with prematurity and birthweight. Beyond the first 28 days of life, ecological and environmental circumstances become more prominent, with leading causes of death turing more towards non-intentional injury. It is also noteworthy to examine racial/ethnic representation in each catagory. For example, more early childhood deaths (0-4) occur among African Americans, despite representing a smaller proportion of the population.//2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	476	43	1
Children 1 through 4	67	4	0
Children 5 through 9	42	1	0
Children 10 through 14	58	4	0
Children 15 through 19	221	16	0
Children 20 through 24	361	32	1
Children 0 through 24	1225	100	2

Notes - 2010

Narrative:
/2010/This indicator provides insight into the distibution of deaths among different age group by Ethnicity. It's important to note the proportion of death among those identified as Hispanic compared to others.//2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1184780	730308	400415	5572	18816	894	28775	0	2008
Percent in household	11.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008

headed by single parent									
Percent in TANF (Grant) families	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Number enrolled in Medicaid	405884	151739	201591	840	0	0	0	51714	2008
Number enrolled in SCHIP	125035	49609	66606	257	0	0	0	8563	2007
Number living in foster home care	5365	0	0	0	0	0	0	5365	2008
Number enrolled in food stamp program	304262	0	0	0	0	0	0	304262	2008
Number enrolled in WIC	30000	0	0	0	0	0	0	30000	2008
Rate (per 100,000) of juvenile crime arrests	527.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	3.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2006

Notes - 2010
13,881/1,184,780 Provided by Steve Rivers at DSS

Provided by Steve Rivers at DSS

WIC collects data on children ages 1-5. We don't collect information on children 1-19. Estimate is given for ages 1-5.

SLED Website

Dept. of Ed Website

Provided by Steve Rivers at DSS

Narrative:
/2010/We have reliable data on Medicaid, SCHIP and WIC that is more detailed than what is presented in this indicator. Historically, the remainder of the data for the specified catagories has been difficult to obtain and is not reliable. Given these challanges, this particular indicator is of limited use.//2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1123760	64960	0	2007
Percent in household headed by single parent	0.0	0.0	11.5	2008
Percent in TANF (Grant) families	0.0	0.0	1.1	2008
Number enrolled in Medicaid	0	26490	379394	2007
Number enrolled in SCHIP	0	5706	119329	2007
Number living in foster home care	0	0	5365	2008
Number enrolled in food stamp program	0	0	304262	2008
Number enrolled in WIC	0	0	30000	2008
Rate (per 100,000) of juvenile crime arrests	1.0	1.0	1.0	2007
Percentage of high school drop-outs (grade 9 through 12)	1.0	1.0	1.0	2007

Notes - 2010
Calculated with SCAN

WIC collect data on children ages 1-5. We don't have data available for children ages 1-19.

Data not available, 1 used as placeholder

Data not available by ethnicity, 1 used as placeholder

Narrative:
/2010/Historically, data provided for this indicator has been difficult to obtain and is not very reliable.//2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**
Living in metropolitan areas	0
Living in urban areas	908560
Living in rural areas	280190
Living in frontier areas	0
Total - all children 0 through 19	1188750

Notes - 2010

Narrative:
/2010/South Carolina is a predominantly rural state. This is important to consider for a several reasons. The concept of medical homes, systems of care and population based services continues to progress while the desire to move away from direct services has increased. Given this trend, consideration should be given to the ramification of these concepts on rural populations. It is well documented individuals residing in rural areas are historically underserved and have less access to care. As public heatlh moves away from

providing direct services, we should be cognizant of the fact this can have an adverse impact in rural and underserved areas with limited healthcare infrastructure.//2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	4379748.0
Percent Below: 50% of poverty	5.8
100% of poverty	14.1
200% of poverty	33.2

Notes - 2010

Narrative:
/2010/Poverty is a social determinant of heath and is linked with a multitude of health problems. South Carolina is a poor State with one of the highest unemployment rates in the US. As poverty increases so does the need for services and potential for increased health issues. This indicator has implications for the underlying health status and need for servcies.//2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1180047.0
Percent Below: 50% of poverty	9.1
100% of poverty	20.6
200% of poverty	43.2

Notes - 2010

Narrative:
/2010/South Carolina is a poor State with 43.2% of persons 0-19 living below 200% of the FPL. Nearly 10% (9.1) live below 505 of the FPL. These numbers are high and certainly contribute the the poor underlying health status of the population and the need for public health services.//2010//

F. Other Program Activities

/2007/In SC, services to children under 16 who receive SSI are administered by SC's Title V CSHCN program known as the SSI/Disabled Children's Program (SSI/DCP). Since the block grant enactment, the program has been integrated into the CSHCN community-based services program. SSI-eligible children not already enrolled are referred to the CRS program for case management services. About 3% of the 100000+ children served by CRS receive SSI. In addition, SSI recipients are referred to DDSN, School for the Deaf and Blind, DMH, and HIV

programs. All referrals are via a MOA with each institution.//2007//

/2009/CSHCN Division staff review and distribute SSI/DCP referrals to the appropriate SC agency for possible case management services. Approximately 34% of CSCHN less than 16 enrolled in CRS receive SSI benefits.//2009//

/2010/ As of December 2008, 16,679 children under age 16 in SC received SSI payments. 24% (4,038) of these under age 16 SSI recipients received a DHEC service in CY2008.//2010//

/2007/Assurance is provided so that SC coordinates activities between MCH and the EPSDT Program under Title XIX. DHEC is an EPSDT service provider to eligible clients. WCS, in coordination with the health regions, provide a small percentage of all SC EPSDT screenings. Other providers include private physicians, FQHCs and hospital outpatient clinics. Where Public Health clinics do not provide the screenings, they are available through private/public partnerships that provide traditional public health supportive services to complement medical care. Public health nurses provide education/assist families in securing a medical home for the children. Once children are in a medical home, local public health staff support the providers/clients to assure adherence to the medical plan outlined by the primary EPSDT provider.

SC's EPSDT Program follows the periodicity schedule recommended by the AAP. WCS was actively involved in the selection of this schedule and was instrumental in providing input into the content of EPSDT screenings. FSS are available as needed by EPSDT clients.//2007//

/2009/The EPSDT Program still follows the AAP recommended periodicity schedule. AAP adopted a new schedule adding additional visits to include an annual well child visit for children from 3 up to 21 years of age. DHEC still encourages well child care in the private sector as holistic medical home care.//2009//

/2010/ DHEC promotes EPSDT provided through medical homes to encourage continuity of care.//2010//

/2007/Assurance is provided that DHEC coordinate with the Title XIX Agency-SC DHHS in providing funding, assisting in the eligibility process and the provision of services to Pregnant Women, Infants and Children in SC. SC offers Medicaid to Pregnant Women and Infants up to 185% of poverty and Children ages 1-18 up to 150% of poverty (with the latest SCHIP expansion). SC began Medicaid expansion in 10/1987. DHEC uses a number of different approaches to identify/assist Medicaid eligible pregnant women/infants. As indicated below, methods include coordination with other agencies as well as the private sector.

WIC income guidelines are revised at the same time as Medicaid's to ensure a coordinated process in identifying those Medicaid eligible. When WIC clients are deemed eligible, appointment are made with the out-stationed Medicaid eligibility workers in County Health Departments, or the County DSS Office, whichever is applicable. SC agencies and the private sector work cooperatively toward the goal of eliminating barriers to Medicaid eligibility which spans the continuum from client identification/assistance with eligibility documentation requirements/eligibility processing at the clinic site/meeting transportation needs, etc., through the process of providing appropriate care/case management.

During 2004, swipe card technology was made available to expedite eligibility determination. Clinics now have the additional option of purchasing a swipe card reader to determine eligibility. However, this technology has come with additional expenses, such as the need for several machines, each with a secure Internet phone line, and a per utilization charge of $0.25. The original option of using a 1-800 toll free number is still available. This option has also become costly because it now takes staff approximately 20 minutes to ascertain eligibility status for a

client.//2007//

/2009/SC does not use swipe care technology for the WIC program. Eligibility is still determined by personal interview.//2009//

Division of HIV/STD

/2008/About 300 women are newly diagnosed with HIV/AIDS each year in SC representing nearly 1 in every 3 new cases (32%). Over 4300 women are living with the disease. DHEC provides HIV counseling/testing services in all 46 county health departments to women in STD and Family Planning clinics. Several community-based organizations provide community-delivered testing/counseling initiatives for women to increase testing access. Women who are infected are actively referred to the HIV care system.

A 10% increase in the number of women/youth tested in local health department clinics is due to 4 health departments receiving Office of Population Affairs FP grants. The grants increased the proportion of women tested in FP clinics and numbers of community partners who provide screening with OraSure and refer positive clients to the health department for follow up screening. In 2004, 2593 women were provided services while in 2006, 3040 women received HIV care services, an increase of 15%.//2008//

/2009/About 240 women are newly diagnosed with HIV/AIDS each year in SC representing 1 in every 3 new cases (30%) with over 4500 women living with the disease. HIV testing/counseling services are provided in all 46 county health departments. Efforts to target women to ensure screening include Ryan White Part D staff working with MCH partners and social service agencies to provide staff development focusing on perinatal prevention messages. Infected women are actively referred to the HIV care system. There was a 30% increase in the number of women tested for HIV in local health department FP clinics from 2005-2007, partially due to 4 health departments receiving Office of Population Affairs FP grants. The HIV care system still serves an increasing number of women. In 2005, 2355 women, 25 years and older were provided services while in 2007, 2761 women of this age group received care services, an increase of over 13%.//2009//

/2010/ HIV counseling and testing services are provided in all 46 county health departments. Efforts to target women to ensure screening include Ryan White Part D staff working with MCH partners and social service agencies to provide staff development focusing on perinatal prevention messages. There was a 14% increase in the number of women tested for HIV in local health department FP clinics from 2006-2008, partially due to 4 health departments receiving Office of Population Affairs FP grants. In 2007, 2754 women, 25 years and older were provided HIV care and support services through the Ryan White Part B program. 2008 data is not yet available.//2010//

Legislation

/2008/The SC State Legislature introduced a Food Assistance Bill, H. 3149 which states that a person may not receive food assistance payments, including WIC, unless the person can show proof that s/he is lawfully present in SC. The bill is currently in Senate Committee. If it passes next year, it will have an impact on illegal immigrants who are over age 18 and pregnant or in need of FP services.

Bill S.518, Shaking Baby Video, passed the SC Legislature, effective 01/2008, requiring hospitals to make available to parents of newborns a video presentation on the dangers of shaking infants and request that the primary caregiver view the video. According to the bill, the Shaking Baby Video and infant CPR information are to be made available to parents/caregivers of newborns, and adoptive parents. DHEC will review/approve the content of all videos prior to distribution. The videos will be distributed to childcare providers who must include the presentation in the training

of facility staff. DHEC will establish a protocol for health care providers to use during well child visits to educate parents/primary caregivers about the dangers of shaking infants/young children.

The SC Legislature approved the expansion of the SCHIP up to 200% of the prevailing poverty level. Enrollment is to begin no sooner than 10/01/2007.//2008//

/2009/SC began taking applications for SCHIP expansion in 04/2008 and enrollment began 05/2008. Legislation was passed requiring an ultrasound be performed on a woman desiring an abortion, making her wait 60 minutes after the ultrasound and offering her the option to view the ultrasound.//2009//

G. Technical Assistance

/2007/South Carolina has identified three areas where technical assistance would be helpful. The first is to enhance and integrate epidemiologic capacity throughout the MCH Bureau. South Carolina has been without an epidemiologist for some time leaving gaps in coverage and methodologies.

The second area of technical assistance requested is to help refine and implement a performance management system that would contain a score card to monitor progress. This relates directly to State Priority and Performance Measure 4: Priority, "Decrease health disparities through the utilization of cost effective strategies monitored through a performance management system," and the related Performance Measure, "Increase the percent of MCH programs that utilize a scorecard of measures to monitor progress." DHEC and the MCH Bureau are at a critical juncture in implementing strategic plans and performance measures. It is imparative that programs are benchmarked and progress monitored.

Currently, the Division that provides the most direct and enabling services is Chidren with Special Health Care Needs. Technical assistance could be helpful as the transition is made down the MCH pyramid to population based services and infrastructure building within that particular division.

South Carolina is open to suggestions as to who would provide the technical assistance in either area.//2007//

/2008/ South Carolina has two identified areas where technical assistance would be helpful. The state would like assistance with enhancing and integrating the epidemiologic capacity throughout the MCH Bureau. South Carolina recently lost the epidemiologist dedicated to MCH activities after being without one for quite some time. The Division of Children with Special Health Care Needs could use technical assistance in its organizational structure, data system, priorities, personnel, contracts, and partnership building as it continues to transition to infracture building. The state is open to suggestions as to whom would be able to provide assistance in either area. //2008//

/2009/SC has identified the following five areas for technical assistance:

1. Maintaining access to healthcare in a Medicaid Managed Care system, particularly for children, including those with special health care needs, and pregnant women.
2. Increasing rates of Post-Partum Newborn Home Visits
3. Preventing infant deaths related to overlays/co-sleeping
4. Increasing the numbers of EPSDT visits for ages 6-12
5. Decreasing minority infant mortality and low birth weight rates//2009//

/2010/ SC has identified the following areas for technical assistance

1. ***Increasing capacity to conduct formal program evaluation***
2. ***Increasing MCH workforce leadership capacity based on MCH Leadership***

competencies //2010//

V. Budget Narrative

A. Expenditures

/2007/Methodology The DHEC Bureau of Maternal and Child Health based the 1989 Maintenance of Effort on the state expenditure of $8,425,466.

FY 1994 was the first year the direct state appropriation for MCH services to the Bureau dropped below the 1989 effort level. The expenditures for FY 1994 were $8,114,682. Therefore, we requested that the 1989 baseline be amended to include expenditures for family planning services. The FY 1989 Family Planning expenditures were $3,020,500.

Identification of Maintenance Effort The State of South Carolina documents a total of $11,445,966 as the 1989 baseline against which future effort is measured. This combines the 1989 state expenditures for maternal and child health services with the Family Planning expenditures.

For FY 2007, state appropriations for the Bureau of Maternal and Child Health Divisions of Women and Children's Services, and Children with Special Health Care Needs are expected to be $11,324,530.

Therefore, the total maintenance of effort for FY 2007 is $12,375,854 calculated by combining the state appropriated dollars for Women and Children's Services and Children with Special Health Care Needs programs of $11,324,530 with the state appropriated dollars for Family Planning of $1,051,324. The State of South Carolina exceeds the 1989 maintenance of effort requirement by $929,618.

Match Title V matching requirements for the FY 2007 grant award of $11,526,057 is $8,644,492. We identify $8,644,492 of the state allocation of $11,324,530 in the Divisions of Women and Children's Services and Children with Special Health Care Needs as match.

Fiscal Management Procedures Division of Finance's fiscal management procedures was provided in the FY 1995 MCH Title V Grant Application. Another copy can be provided upon request.

Fair Method of Allocating Grant Funds See the attached file for a description of the method used by South Carolina for allocating its MCH and CSHCN funds to the public health regions.//2007//

/2008/Methodology: The DHEC Bureau of Maternal and Child Health based the 1989 Maintenance of Effort on the state expenditure of $8,425,466.

FY 1994 was the first year the direct state appropriation for MCH services to the Bureau dropped below the 1989 effort level. The expenditures for FY 1994 were $8,114,682. Therefore, we requested that the 1989 baseline be amended to include expenditures for family planning services. The FY 1989 Family Planning expenditures were $3,020,500.

Identification of Maintenance Effort: The State of South Carolina documents a total of $11,445,966 as the 1989 baseline against which future effort is measured. This combines the 1989 state expenditures for maternal and child health services with the Family Planning expenditures.

For FY 2008, state appropriations for the Bureau of Maternal and Child Health Divisions of Women and Children's Services, Children with Special Health Care Needs, and Perinatal Systems are expected to be $13,226,811.

Therefore, the total maintenance of effort for FY 2008 is $14,300,654 calculated by combining the state appropriated dollars for Women and Children's Services, Children with Special Health Care

Needs, and Perinatal Systems programs of $13,226,811 with the state appropriated dollars for Family Planning of $1,073,841. The State of South Carolina exceeds the 1989 maintenance of effort requirement by $2,854,688.

Match: Title V matching requirements for the FY 2008 grant award of $11,526,057 is $8,644,492. We identify $8,644,492 of the state allocation of in the Divisions of Women and Children's Services and Children with Special Health Care Needs as match.

Fiscal Management Procedures: The Bureau of Financial Management procedures can be provided upon request.//2008//

/2009/Methodology: The DHEC Bureau of Maternal and Child Health based the 1989 Maintenance of Effort on the state expenditure of $8,425,466.

FY 1994 was the first year the direct state appropriation for MCH services to the Bureau dropped below the 1989 effort level. The expenditures for FY 1994 were $8,114,682. Therefore, we requested that the 1989 baseline be amended to include expenditures for family planning services. The FY 1989 Family Planning expenditures were $3,020,500.

Identification of Maintenance Effort: The State of South Carolina documents a total of $11,445,966 as the 1989 baseline against which future effort is measured. This combines the 1989 state expenditures for maternal and child health services with the Family Planning expenditures.

For FY 2009, state appropriations for organizational units under the direction of the state Maternal and Child Health Director are expected to be $16,140,604 and is the amount identified for the FY 2009 maintenance of effort. The State of South Carolina exceeds the 1989 maintenance of effort requirement by $7,715,138.

Match: Title V matching requirements for the FY 2009 grant award of $11,526,057 is $8,644,492. DHEC identifies $8,644,492 of the state allocation in the Maternal and Child Health and Children with Special Health Care Needs organizations as match.

Fiscal Management Procedures: The Bureau of Financial Management procedures can be provided upon request.//2009//

/2010/Methodology: The DHEC Bureau of Maternal and Child Health based the 1989 Maintenance of Effort on the state expenditure of $8,425,466.

FY 1994 was the first year the direct state appropriation for MCH services to the Bureau dropped below the 1989 effort level. The expenditures for FY 1994 were $8,114,682. Therefore, we requested that the 1989 baseline be amended to include expenditures for family planning services. The FY 1989 Family Planning expenditures were $3,020,500.

Identification of Maintenance Effort: The State of South Carolina documents a total of $11,445,966 as the 1989 baseline against which future effort is measured. This combines the 1989 state expenditures for maternal and child health services with the Family Planning expenditures.

For FY 2010, state appropriations for organizational units under the direction of the state Maternal and Child Health Director are expected to be $15,506,362 and is the amount identified for the FY 2009 maintenance of effort. The State of South Carolina exceeds the 1989 maintenance of effort requirement by $7,080,896.

Match: Title V matching requirements for the FY 2009 grant award of $11,407,861 is $8,555,896. We identify $8,555,896 of the state allocation in the Women and Children's

Services and Children with Special Health Care Needs organizations as match.

Fiscal Management Procedures: The Bureau of Financial Management procedures can be provided upon request.//2010//

B. Budget

/2007/"30-30 Minimum" As required by OBRA '89, South Carolina allocates a minimum of 30% of Federal Block Grant Funds for preventive and primary care services to children, and a minimum of 30% is allocated to children with special health care needs that are part of a system of services which promotes family-centered, community based coordinated care.

A new budget analyst has been assigned to work with the MCH Block Grant for South Carolina. The methodologies used for computing the numbers are being revised to align more closely with our agency's policies. In some cases, the amounts have shifted between categories and sub-categories.

The Agency uses the Personnel Cost Accounting System (PCAS) to document personnel expenses. Annually MCH staff review PCAS codes and realign with the levels of the MCH pyramid.

The Bureau and the Agency continue to work toward devoting more resources, effort and expenses down the MCH pyramid to enabling, population based and infrastructure activities and interventions. During the past few years of decreasing budgets, this has been and continues to be a challenge.

Due to the above activities, shifts in expenses by the pyramid levels have occurred in the past few years.//2007//

/2008/"30-30 Minimum" As required by OBRA '89, South Carolina allocates a minimum of 30% of Federal Block Grant Funds for preventive and primary care services to children, and a minimum of 30% is allocated to children with special health care needs that are part of a system of services which promotes family-centered, community based coordinated care.

We continue to automate financial methodologies to more accurately collect and compute MCH Block grant and related expenditures. As these efficiencies are realized, the result is shifting amounts between categories and subcategories.

The Agency uses the Personnel Cost Accounting System (PCAS) to document personnel expenses. Annually MCH staff review PCAS codes and realign with the levels of the MCH pyramid.

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Due to the above activities, shifts in expenses by the pyramid levels continue to occur.//2010//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.